Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6503

Registered No. 27

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Fremont

City of Rigby (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Cutler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: May 17 1830 (Month) (Day) (Year)

7. AGE: 83 yrs. 7 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Unk.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. W. Cutler
(Address) Annis

15. Filed Jan 10 1914 Roy V. Fisher By [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 4 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw h alive on 191, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

in a Contributory

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Roy V. Fisher M. D.

Jan 5 1914 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Cemetery | DATE OF BURIAL: Jan. 7 1914

20. UNDERTAKER: M. Peck & Sons | ADDRESS: Rigby Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 98
County of Jefferson Primary Registration District No. 2176
City of Spencer (No. St.)
File No. 6506
Registered No. 25
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Spencer Horwood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word.)
M	W	Married

6. DATE OF BIRTH Oct 12 (Month) (Day) 1863 (Year)

7. AGE 50 yrs. 2 mos. 24 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or dstablishment in which employed (or employer) Merchant

9. BIRTHPLACE (State or Country) West Va.

10. NAME OF FATHER J. A. Horwood.

11. BIRTHPLACE OF FATHER (State or Country) West Va.

12. MAIDEN NAME OF MOTHER Phoebe Spencer.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alma G. Horwood
(Address) Spencer Idaho.

15. Filed Jan 10 1914 Ray D. Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 5 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1914, to Jan 5 1914, that I last saw h[e] alive on Jan 5 1914, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Cline M. D.

Jan 6 1914 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spencer Ida	Jan 8 1914

20. UNDERTAKER	ADDRESS
C. E. Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6515

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Kuna
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Lewis Augustus Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 19 (Day) 1857 (Year)

7. AGE: 56 yrs. 10 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Banker
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: John E. Martin

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Wady Carruthers

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J E Martin
(Address): Notus Idaho

15. Filed Jan 16th 1914 O. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16th 1914, to 191
that I last saw him alive on Jan 16th 1914,
and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:
Accidental gun shot
in brain (Right temple)
Lived Three hours and a half.
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Joseph R. Numbers M. D.
Jan 16 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho
DATE OF BURIAL: Jan 18 1914

20. UNDERTAKER: F. K. Robinson
ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Bohannan Bar (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116

File No. 6532
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John J McCracken.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH (Month) November (Day) 29th (Year) 1878

7. AGE 34 yrs. 1 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER F. P. McCracken.

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Emma C Lang.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank P McCracken
(Address) Salmon Ida.

15. Filed 1-2 1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH January 2nd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Accidental
Caving of Bank by Striking
Head on Ice or Drowning?
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Coroner In and for Lemhi county State of Ida.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C Doebler Coroner M. D.
1-2 1914 (Address) Salmon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery
DATE OF BURIAL Jan 4th 1914
20. UNDERTAKER J. C. Hocker
ADDRESS Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8
Registered No. 6544

1. PLACE OF DEATH.
County of
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2202
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Robert Peter Hull

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: March 2 1 (Month) (Day) (Year)
7. AGE: 43 yrs. 11 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Motorman
(b) General nature of industry business or establishment in which employed (or employer): Lead mine
9. BIRTHPLACE (State or Country): West Virginia
10. NAME OF FATHER: Do not know
11. BIRTHPLACE OF FATHER (State or Country): Do not know
12. MAIDEN NAME OF MOTHER: Do not know
13. BIRTHPLACE OF MOTHER (State or Country): Do not know.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Emma Hull
(Address): Wardner Idaho
15.
Filed Jan 4 1914 Geo. D. Lasher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 4 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from January 3 1914, to January 4 1913, that I last saw him alive on January 4 1913, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Shock following amputation of left thigh for compound fracture sustained in accident

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary): Compound fracture of left femur

(Duration) — yrs. — mos. 2 ds.

(Signed) Alexander David McEachin M. D.
Jan. 6 1914 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. 2 ds. In the State 16 yrs. — mos. — ds.
Where was disease contracted, if not at place of death?
~~Former~~ or usual residence: Kellogg, Idaho.

19. ~~PLACE OF BURIAL OR~~ REMOVAL: Gap Mills W Virginia. DATE OF BURIAL: 191

20. UNDERTAKER: Bruce G. Worstell ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2078
File No. 6606
Registered No. 45

1. PLACE OF DEATH.
County of Madison
City of Sugar
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arron DeWaine Camphouse
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
10 (Month) Dec (Day) 1910 (Year)

7. AGE
3 yrs. mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Camphouse

11. BIRTHPLACE OF FATHER (State or Country) Holland.

12. MAIDEN NAME OF MOTHER Lina Carolina Hill

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Camphouse
(Address) Salem

15.
Filed 1-6 1914 L. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis Laryngitis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Phipps M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar City	Jan. 7 1914

20. UNDERTAKER	ADDRESS
John Phillips	Rexburg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178
City of Rexburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 6607
Registered No. 46
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie L. Jaques

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: June (Month) 27 (Day) 1867 (Year)

7. AGE: 46 yrs. 6 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Jaques

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Tiltah Loader

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Jaques
(Address) Rexburg

15. Filed 1 – 6 1914 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1913 to Jan 6 1914
that I last saw h[illegible] alive on Jan 1 1914
and that death occurred on the date stated above, at 6.9 M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency &
Myocarditis
(Duration) 25 yrs. – mos. – ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
1/6 1914 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: Jan 8 1913

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6609
Registered No. 47

1. PLACE OF DEATH.
County of Madison
City of Redburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2178
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Margaretta Beguet.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH
Jan. (Month) 6 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Redburg

10. NAME OF FATHER John Bergeet

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Emma Whitmer

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Bergert
(Address) Redburg

15.
Filed 1-7 1914 L. K. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6 1914, to Jan. 7, 1914, that I last saw h.e alive on Jan. 6, 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Cusmore M. D.
Jan. 7, 1914 (Address) Redburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds
In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Redburg
DATE OF BURIAL: 1/7 1914

20. UNDERTAKER: John Phillips
ADDRESS: Redburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 45

Primary Registration District No. 2128

File No. 6657

County of Lewis

City of Kamiah (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Moses Hull Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	Widowed

6. DATE OF BIRTH

Mar (Month) 23rd (Day) 1836 (Year)

7. AGE

77 yrs. 9 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER James Price

11. BIRTHPLACE OF FATHER (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Nancy Bean

13. BIRTHPLACE OF MOTHER (State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miles Price

(Address) Winnipeg Canada.

15.

Filed 1-8 1914 E. Taylor Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 23 1913, to 1/6 1914, that I last saw him alive on Dec. 20th. 1913, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.

1/7 1914 (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt. Idaho — DATE OF BURIAL: Jan. 9th 1914

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5 (
Primary Registration District No. 2130
(No. ....., ... St.)

File No. 6668
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold Sargent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 30 (Day) 1913 (Year)

7. AGE: — yrs. — mos. 8 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Curtis H Sargent

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Clara Eldridge

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Stimler
(Address) Fruitland Ida

15. Filed Jan. 8th 1914 C. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30 1913, to Jan. 7th 1914, that I last saw him alive on Jan 7th 1914, and that death occurred on the date stated above, at 7 3/4 A.M.

The CAUSE OF DEATH* was as follows: Congenital Toxemia of Debility, caused by Toxemia of Mother. Immediate Cause was Convulsions

(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Convulsions
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chapin Wright M. D.
Jan 8 1914 (Address) Fruitland

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette | DATE OF BURIAL: Jan 8 1914

20. UNDERTAKER: D N Adair | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 6681
Registered No. 5

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. 4, St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold W. King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Dec. 26 1910 (Month) (Day) (Year)

7. AGE: 3 yrs. mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mill Creek

10. NAME OF FATHER W. King

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Mary Wolshouser

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs F E. Shallow
(Address) Coeur d Alene

15. Filed Jan 10 1914 Mark Sloan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/2/14 191.., to 1/4/14 191.., that I last saw h[illegible] alive on 1/4/14 191.., and that death occurred on the date stated above, at 7. P. M.

The CAUSE OF DEATH* was as follows:
Burns of buttocks & legs from falling in to tub of hot water

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) .....
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
1/5/14 (Address) Coeur d'alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE ~~OF BURIAL OR~~ REMOVAL: Dongola Ill. DATE OF BURIAL: 1914

20. UNDERTAKER: Gus Nelson ADDRESS: Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PTRS. & BDRS. 19760

5

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6692

Registered No. 87

1. PLACE OF DEATH.

County of Cassia

City of Oakley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120

Primary Registration District No. 2199.

(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse Wilbert Bess

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec. 5 1900 (Month) (Day) (Year)

7. AGE: 13 yrs. 1 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: O. C. Bess.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma Lee

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. C. Bess
(Address) Oakley Idaho

15. Filed 1-7-1914 E. W. Oham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 6 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6. 1914 to Jan. 6 1914, that I last saw him alive on Jan. 6. 1914 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) — yrs. 9 mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. 12 ds.

(Signed) E. W. Oham M. D.

1/7 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, – Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: 1-8 1914

20. UNDERTAKER: Bp O B Puckett — ADDRESS: Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 6785
Registered No. 1

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Katherine Braunsreiling

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Sep 18, (Month) (Day) 1833 (Year)

7. AGE: 80 yrs. 9 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Meer Germany

10. NAME OF FATHER: Bengel Brun

11. BIRTHPLACE OF FATHER (State or Country): Meer Germany

12. MAIDEN NAME OF MOTHER: Johanna Bissing

13. BIRTHPLACE OF MOTHER (State or Country): Holstein Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herman Braunsreiling
(Address) Genesee Ida

15. Filed Jan 25 — 1914 W H Eden Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 24 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1914, to Jan 23 1914, that I last saw h[illegible] alive on Jan 23 1914 and that death occurred on the date stated above, at 6:30 PM

The CAUSE OF DEATH* was as follows:
Pulmonary Oedema

(Duration) yrs. 2 mos 3 ds.

Contributory (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. ds.

(Signed) C. T. Guernsey M. D.

Jan 1914 (Address) Genesee Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 14 yrs. 9 mos. days. In the State 75 yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Marys Cemetery | DATE OF BURIAL: Jan 26 1914

20. UNDERTAKER: J E Lambert | ADDRESS: Genesee Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Canyon

Primary Registration District No. 216 1

File No. 6786

City of Notus (No. ....., ... St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Floyd Harriett

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White	Single.

6. DATE OF BIRTH: Oct. (Month) 27th (Day) 1913. (Year)

7. AGE: ..... yrs. 2 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Infant.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Notus, Idaho

10. NAME OF FATHER George Harriett.

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Gertrude Allen.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo H Harriett
(Address) Notus

15. Filed Jan. 15 1914 T.E. Martin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 13th (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1914, to Jan. 13th 1914, that I last saw him alive on Jan 12th 1914, and that death occurred on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary) Marasmus & Status Neonatorum

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T E Martin M. D.

Jan. 13 1914 (Address) Notus, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Caldwell, Ida.	Jan. 14 1914

20. UNDERTAKER	ADDRESS
Geo. Harriett Snell	Notus, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6787
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020

2. FULL NAME Richard Hopkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF ~~BIRTH~~ death: January 19 1914 (Month) (Day) (Year)

7. AGE: 36 yrs. ____ mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Can't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. H. Eaton, Coroner
(Address) Mtn Home, Ida.

15. Filed Jan. 21st 1914 B. W. Mather Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19th 1914, to ____ 191__, that I last saw him alive on Jan. 19th 1914, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Internal haemorrhage
accidental fall from
30 ft.
(Duration) 1 yrs. ____ mos. 1 ds.

Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) B. W. Mather M. D.
1/19 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida
DATE OF BURIAL: Jan 22 1914

20. UNDERTAKER: J. M. Bowen
ADDRESS: Mtn Home

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6788
Registered No. 2

1. PLACE OF DEATH.
County of Elmore
City of Indian Cove (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020

2. FULL NAME Emeline Page

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Dec. 22nd 1852 (Month) (Day) (Year)

7. AGE: 62 yrs. 1 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Ely
(Address) Indian Cove

15. Filed Jan. 28th 1914 B. W. Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 27th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8th 1913, to July 23d 1913 that I last saw her alive on July 23d 1913, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 2 yrs. — mos. — ds.
Contributory (Secondary) Pulmonary Haemorrhage
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) B. W. Walker M. D.
1/28 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home
DATE OF BURIAL: Jan. 29th 1914

20. UNDERTAKER: J. M. Cowen
ADDRESS: Mountain Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6790
Registered No. 3

1. PLACE OF DEATH.
County of Franklin
City of Round Co
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

2. FULL NAME Ezra Nelson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: September (Month) 21 (Day) 1871 (Year)

7. AGE: 33 yrs. 4 mos. ds.
IF LESS than 1 day how many ..... hm. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Franklin

10. NAME OF FATHER: Wm G. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Elvira Vail

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Taylor Nelson
(Address) Preston Ida

15.
Filed 1/12 1914 D. Allen R Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1914, to Jan 8 1914
that I last saw him alive on Jan 8 1914
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis following a Gunshot wound Self Inflicted

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen R Curtis M. D.
19 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverdale — DATE OF BURIAL: Jan 11 1914

20. UNDERTAKER: D J Hansen — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

Primary Registration District No. 2119

File No. 6791

County of Franklin

City of Fairview (No. ....., ... St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Matthew Taylor

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Oct. 10 1845
(Month) (Day) (Year)

7. AGE: 68 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: John Taylor

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Richard Taylor
(Address) Fairview

15.
Filed 22 - Jul 1917 D Allen Coates
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1913, to January 16 1914, that I last saw h[illegible] alive on June 16 1914, and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:
Cystitis (Chronic)

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. O. B. Canfield M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview | DATE OF BURIAL: [illegible] 191[illegible]

20. UNDERTAKER: O. J. Thomsen | ADDRESS: Fairview

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6792

Registered No. 8

1. PLACE OF DEATH.

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ria B Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH

Jan (Month) 23 (Day) 1914 (Year)

7. AGE

..... yrs. ..... mos. ..... ds. 9 hrs

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Preston

10. NAME OF FATHER Anton A Jensen

11. BIRTHPLACE OF FATHER (State or Country) Denton

12. MAIDEN NAME OF MOTHER Boreham

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. A. Jensen

(Address) Preston

15.

Filed 1/25 1914 Allen R Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/23 1914, to 1/23 1914 that I last saw h/r alive on 1/23 1914 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature - 7½ months.
Lived only 8 hours

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen R Curtis M. D.

1/24-1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Jan 25 1914
20. UNDERTAKER	**ADDRESS**
O J Hansen	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Riverdale
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2169
(No. ....., ... St.)

File No. 6793
Registered No. 6

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wanetta Talman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Jan (Month) 3 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Riverdale

10. NAME OF FATHER: Judson Talman

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Call

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Judson A Talman Jr
(Address) Preston R D 2 No 1

15. Filed 1/27 1914 Allen Allred Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 24 1914, to Jan 25 1914, that I last saw her alive on Jan 24 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ✓ yrs. ✓ mos. 2 ds.
Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Guy Slater M. D.
Jan 26 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverdale — DATE OF BURIAL: Jan 29 1914

20. UNDERTAKER: G J Hansen — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6794

Registered No. 10

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ....., ... St.)

2. FULL NAME Seth Lance

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Not Known (Month) ..... (Day) 1 (Year)

7. AGE: 54 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Lance

(Address) Preston Idaho

15.

Filed 2/2 1914 Allen R Rudd
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan ~~Dec~~ (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1914, to Jan 28 1914, that I last saw h[illegible] alive on Jan 28 1914, and that death occurred on the date stated above, at 3A M.

The CAUSE OF DEATH* was as follows:

Intestinal tuberculosis

(Duration) ~ yrs. 4 mos. ~ ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W Stales M. D.

Jan 31 1914 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Whitney — DATE OF BURIAL: Feb 1 1914

20. UNDERTAKER: G J Hansen — ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2 4 9
(No. ....., ... St.)

File No. 6795
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob D Nuffer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): [redacted]
6. DATE OF BIRTH: Oct 24 1912 (Month) (Day) (Year)
7. AGE: 1 yrs. 2 mos. 11 ds. IF LESS than 1 day how many .....hrs. or .....mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Fairview
10. NAME OF FATHER: Fred Nuffer
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Rinderknecht
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE REST OF MY KNOWLEDGE
(Informant) Fred Nuffer
(Address) Preston Idaho
15.
Filed 1/16/14 1914 Allen R Call Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January 16 1914
January (Month) 16 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1914, to Jan 16 1914, that I last saw him alive on Jan 16 1914, and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) yrs. mos. 2 ds.
Contributory (Secondary) .....
(Duration) yrs. mos. ds.
(Signed) Dr H Caufield M. D.
1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: Jan 18 1914
20. UNDERTAKER: D J Hansen — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 2469

File No. 6796

City of Weston (No. ....., ... St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W Ellis

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH

Apr (Month) 6 (Day) 1841 (Year)

7. AGE

1 yrs. 9 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Smithfield Utah

10. NAME OF FATHER Geo W Ellis

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Nisson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Nielsen

(Address) Weston

15.

Filed 1/14 1914 Allen R Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at 11:20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Always Delicate

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. J. Parkinson M. D.

19.... (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Logan Utah	Jan 16 1914

20. UNDERTAKER	ADDRESS
O J Hansen	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 2 1 6 9

File No. 6797

City of Preston (No. ....., ... St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willis J Condie

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: July (Month) 3 (Day) 1874 (Year)

7. AGE: 39 yrs. 6 mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Horse Worker
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thos E Jones

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Cleora Jones

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas R. Condie

(Address) Preston Idaho.

15.

Filed 1/7 191 Allen Rueter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20 1913, to Jan 4 1914, that I last saw h/s alive on Jan 2 1914, and that death occurred on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows: Exhaustion from Epilepsy

(Duration) 15 yrs. 1 mos. ..... ds.

Contributory (Secondary) Epilepsy

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) Allen Rueter M. D.

19 .... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: Jan 8 1914

20. UNDERTAKER: D J Hansen — ADDRESS: Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19750

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2109
(No. ....., ... St.)

File No. 6798
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachel Ann Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: May (Month) 16 (Day) 1830 (Year)

7. AGE: 83 yrs. 7 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer Widow
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Murray

11. BIRTHPLACE OF FATHER (State or Country): N Y

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N B Carter
(Address) Preston R 5 B 1

15.
Filed 1/13 1914 Allen R Rutter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 to Jan 9, 1914, that I last saw h— alive on —, 191..., and that death occurred on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:
Paralytic Stroke
Old age

(Duration) yrs. 3 mos. — ds.
Contributory (Secondary) Senile decay
(Duration) yrs. mos. ds.

(Signed) Allen R Rutter M. D.
19... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Jan 10 1914
20. UNDERTAKER	ADDRESS
O J Hansen	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M-1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2 1 9
(No. ....., ... St.)

File No. 6799
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry A Hyde

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH
Dec (Month) 29 (Day) 1883 (Year)

7. AGE
30 yrs. 3 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER James A Hyde

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Driggs

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R J Hyde
(Address) Fairview

15.
Filed 1/6 1914 Allen R Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 26 1914, to January 31 1914, that I last saw h[illegible] alive on Jan 31 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Peritonitis following appendicitis (Operation)
(Duration) ✓ yrs. ✓ mos. 5 ds.
Contributory (Secondary) Chronic appendicitis
(Duration) 4 yrs. 2 mos. ✓ ds.
(Signed) L G W Stokes M. D.
Jan 31 1914 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairview	Feb 2 1914

20. UNDERTAKER	ADDRESS
C J Hansen	Preston

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6800

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 87

Primary Registration District No. 2154

County of Washington

City of Midvale

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lela Elizabeth Lakey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Girl	White	~~Single~~ (Write the word.)

6. DATE OF BIRTH. Jan (Month) 13? (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Midvale Idaho.

10. NAME OF FATHER Chas Lakey

11. BIRTHPLACE OF FATHER (State or Country) Of Oregon.

12. MAIDEN NAME OF MOTHER Callie Point

13. BIRTHPLACE OF MOTHER (State or Country) Salubria Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Lakey

(Address) Midvale Idaho

15. Filed Jan 31 24 1914

Houston E Buyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1914, to Jan 30 1914, that I last saw h... alive on Jan 30 1914, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Heart lesion

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

Jan 31 1914 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Midvale Idaho — DATE OF BURIAL Feb. 1 1914

20. UNDERTAKER I G Kay — ADDRESS Midvale Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACT; that it may be properly classified. Exact statement should state CAUSE OF DEATH in plain terms, so of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PE...

MARGIN RESERVED FOR BINDING

BYRNE-YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6801
Registered No.

1. PLACE OF DEATH
County of Washington
City of Midvale
Registration District No. 7
Primary Registration District No. 21
(No. 8 miles N. E. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Emma Hubbard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Dec – 9 – 1856 (Month) (Day) (Year)

7. AGE: 57 yrs. 1 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of Penn.

10. NAME OF FATHER: Nathan Weston

11. BIRTHPLACE OF FATHER (State or Country): State of Penn.

12. MAIDEN NAME OF MOTHER: Emma Rhinvalt

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): George Heman
(Address): Midvale; Idaho.

15.
Filed Jan 20 1914 Houston E Snyder
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan – 19 – 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1914, to Jan 15 1914 that I last saw her alive on Jan 15 1914 and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Paralysis
Cerebral Hemorrhage

(Duration) 2 yrs. 3 mos. 7 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Houston E Snyder M. D.
Jan 19 1914 (Address) Midvale; Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pullman; Washington
DATE OF BURIAL: Jan 22 1914

20. UNDERTAKER: R. W. Bowen
ADDRESS: Weiser; Ida.

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6802
Registered No. 3

1. PLACE OF DEATH.
County of Canyon
City of Oakley (No. ....., ... St.)

Registration District No. 170
Primary Registration District No. 7199

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gerald Ephraim Crapes.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 14 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oakley Idaho

10. NAME OF FATHER: Eph. Crapes

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annie Blackenship

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Nielson
(Address) Oakley Idaho

15. Filed ..... 191...
E P Oldham
Local Registrar
By .....

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1914, to Jan 31 1914
that I last saw him alive on Jan 31, 1914
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia Neonatorum

(Duration) — yrs. — mos. 14 ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) W. F. Nielson M. D.
1/31 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6803

Registered No. 7

1. PLACE OF DEATH.
County of Cassia
City of Oakley

Registration District No. 190
Primary Registration District No. 7199
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Hansen White

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: Jan (Month) 8 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oakley Idaho

10. NAME OF FATHER: John White

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Alice Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Nelson
(Address) Oakley Idaho

15. Filed 1/2 1914 C. A. Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8th 1914, to Jan 9th 1914, that I last saw him alive on Jan 9th 1914, and that death occurred on the date stated above, at 9.50 P.M.

The CAUSE OF DEATH* was as follows:

Pemphigus Neonatorum

(Duration) — yrs. — mos. 6 hours

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Nelson M. D.
1-10 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oakley Ida.	1-11 1914

20. UNDERTAKER: E. W. Rose — ADDRESS: Oakley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF VITAL STATISTICS
Bureau of Vital Statistics
File No. 10504
Registered No. 1

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ....., ... St.)

Registration District No. 120
Primary Registration District No. 199

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Northington

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH: Dec. (Month) 11th (Day) 1867 (Year)
7. AGE: 46 yrs. 3 mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Kansas
10. NAME OF FATHER: Horton Knight
11. BIRTHPLACE OF FATHER (State or Country): New York
12. MAIDEN NAME OF MOTHER: Louisa Leavitt
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. Northington
(Address) Oakley Idaho
15.
Filed 1/31 1914 E. A. Graham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 30 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 30 - 1913, to Jan 30 1914 that I last saw h[illegible] alive on Jan 30th 1914, and that death occurred on the date stated above, at 5.55 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (Duration) — yrs. — mos. 4 ds.
Contributory (Secondary) Myocarditis
..... (Duration) 2 yrs. — mos. ..... ds.
(Signed) W. O. Nichols M. D.
Jan 31 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley — DATE OF BURIAL: 2/1 1914
20. UNDERTAKER: W. A. McBride — ADDRESS: Oakley Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6805
Registered No. 16

1. PLACE OF DEATH.
County of Boise
City of Placerville
Registration District No. 12
Primary Registration District No. 2019
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ah See

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Chinese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE: about 70 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer): Day Laborer

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Feb 8 1914 — G J Fitz — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from never 191..., to attended time 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Old age - unknown -
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G J Fitz M. D.
Feb 8 1914 (Address) Placerville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Placerville
DATE OF BURIAL: Jan 10 1914

20. UNDERTAKER: Hadmore
ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6806

Registered No. 17

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

N[illegible] PLACE OF DEATH.

County of Boise

City of Grimes Pass (No. ....., ... St.)

Registration District No. 12

Primary Registration District No. 2019

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Calderwood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH: 3 (Month) ..... (Day) 1843 (Year)

7. AGE: 63 yrs. 10 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maine.

10. NAME OF FATHER: unknown.

11. BIRTHPLACE OF FATHER (State or Country): U. S. America

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): U. S. America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Feb 8 1914 G. G. Fitz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) – 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1913, to Jan 21 1914
that I last saw him alive on Dec 6 1914
and that death occurred on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:
Chronic Dilitation of the heart

..... (Duration) unknown yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. G. Fitz M. D.
Feb 8 1914 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Garden Valley. DATE OF BURIAL: Jan 23 1914

20. UNDERTAKER: Had none. ADDRESS: .

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6807
Registered No. 18

1. PLACE OF DEATH.
County of Boise
City of Garden Valley
Registration District No. 12
Primary Registration District No. 2019
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Timothy Chesnower Sr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): widowed
6. DATE OF BIRTH: 7 (Month) ..... (Day) 1846 (Year)
7. AGE: 67 yrs. 6 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (State or Country): America
12. MAIDEN NAME OF MOTHER: — Skidmore
13. BIRTHPLACE OF MOTHER (State or Country): America
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....
15. Filed Feb 8 1914 — May Fitz Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) — 24 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1914, to Jan 21 1914 that I last saw him alive on Jan 21 1914 and that death occurred on the date stated above, at 4 A. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Fitz M. D.
Feb 8 1914 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton
DATE OF BURIAL: Jan 24 1914
20. UNDERTAKER: Wadmore
ADDRESS: .....

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Entirely item 6. Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6808
Registered No. 19

1. PLACE OF DEATH.
County of Boise
City of Gardens Valley (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2019

2. FULL NAME John Thomas Scandlin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH: 1 (Month) – 16 (Day) 1914 (Year)
7. AGE: ..... yrs. ..... mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: John J. Scandlin
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Agnes Swickhart
13. BIRTHPLACE OF MOTHER (State or Country): Michigan
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....
15. Filed Feb 8 1917 — G. G. Fitz, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 2 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1914, to Feb 2 1914, that I last saw him alive on Feb 2 1914 and that death occurred on the date stated above, at 6 a. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Fitz M. D.
Feb 8 1914 (Address) Placerville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gardens Valley — DATE OF BURIAL: Feb 3 1914
20. UNDERTAKER: Dad Morris — ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 6809

Registered No. 4

County of Madison

City of Rexburg (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth G. Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec. (Month) 24 (Day) 1913 (Year)

7. AGE: ..... yrs. ..... mos. 17 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. Fred Smith

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Josephine Jurkinson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Fred Smith
(Address) Redmre

15. Filed 1 — 11 1914 G. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 1914, to 1/10 1914, that I last saw h[illegible] alive on 1/10 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. Walker M. D.

19.... (Address) Rexburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 1/12 1914

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Redmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 6810
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margorie Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH
Dec. (Month) 12 (Day) 1912 (Year)

7. AGE
1 yrs. ..... mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank L. Davis

11. BIRTHPLACE OF FATHER (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Alvaretta Harmon

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred Ricks
(Address) Sugar City

15.
Filed 1-11 191[illegible] G. L. Esp
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1913, to 1/10 1914
that I last saw h[illegible] alive on 1/[illegible] 1914,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. P. Lincoln M. D.
1/11 1914 (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 1/11 1914

20. UNDERTAKER: John D Phillips — ADDRESS: Redmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 6811
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Royal Oldham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH: Jan (Month) 10 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or datablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER S P Oldham

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Lucy Schow

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. P. Oldham
(Address) Rexburg

15.
Filed 1-13 1914 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1914, to Jan 13 1914 that I last saw h[illegible] alive on Jan. 13 1914 a. and that death occurred on the date stated above, at 4 1/2 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoid Abdominal Tumor
Duration

(Duration) — yrs. — mos. 3 hrs ds.

Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
1/13 1914 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	Jan 15 1914
20. UNDERTAKER	ADDRESS
John Phillips	Rex

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6812
Registered No. 7

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Floyd Alma Hertzig

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Bale

6. DATE OF BIRTH: Sept. (Month) 18 (Day) 1911 (Year)

7. AGE: 2 yrs. 4 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Babe
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Burton Idaho

10. NAME OF FATHER: Alma Hertzig

11. BIRTHPLACE OF FATHER (State or Country): Utah -

12. MAIDEN NAME OF MOTHER: Mary - N - Chandler

13. BIRTHPLACE OF MOTHER (State or Country): Egin Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary N Hertzig
(Address) Rexburg - Idaho

15.
Filed 1-15- 1914 L. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 15, (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 9 1914, to Jan. 15 1914 that I last saw h[illegible] alive on Jan. 14 1914, and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs. ..... mos. 20 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Cannon M. D.
Jan. 15, 1914 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 1/18 1914

20. UNDERTAKER: J Gormley — ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DYER-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 6 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF [illegible]
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 100
County of Madison
Primary Registration District No. 2178
File No. 681
City of Plano (No. ....., ... St.)
Registered No. 8
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Man	White	married Married

6. DATE OF BIRTH
October 17 1828
(Month) (Day) (Year)

7. AGE
85 yrs. 2 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Christiania Norway

10. NAME OF FATHER
Peter Peterson

11. BIRTHPLACE OF FATHER
(State or Country) Christiania Norway

12. MAIDEN NAME OF MOTHER
Annie Marie Olsen

13. BIRTHPLACE OF MOTHER
(State or Country) Christiania Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ephraim Peterson
(Address) Plano Madison County

15.
Filed 1-18 1914
G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January 16 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jany 4 1914, to Jany 16 1914
that I last saw him alive on Jany 12 1914,
and that death occurred on the date stated above, at 5:25 P.M.

The CAUSE OF DEATH* was as follows:
Old age with Hypostatic Pneumonia following
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. G. Espe M. D.
19 ..... (Address) Plano Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ogden Utah	1/19 1914

20. UNDERTAKER	ADDRESS
J Rymer	Ryburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 6814
Registered No. 9
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James H Hunt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Bale

6. DATE OF BIRTH
Aug (Month) 28 (Day) 1913 (Year)

7. AGE
yrs. 4 mos. 27 ds.
IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Bale
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sugar

10. NAME OF FATHER Jacob Hunt

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Esther Campbell

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob Hunt
(Address) Sugar

15.
Filed 1-26 1914 G. G. Epps
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1914, to Jan 24 1914, that I last saw him alive on Jan 24 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia.

4 (Duration) — yrs. — mos. 4 ds.
Contributory (Secondary) Bronchio-Pneumonia
(Duration) — yrs. — mos. — ds.

(Signed) J. R. Shupe M. D.
19 (Address) Sugar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Sugar | DATE OF BURIAL: 1/26 1914

20. UNDERTAKER: J. Wyoma | ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 6816
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME [redacted] Rosalia Naef

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	married

6. DATE OF BIRTH
June (Month) 10 (Day) 1869 (Year)

7. AGE
44 yrs. 7 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER J. U. Haderlie

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Annie Hallinger

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Naef
(Address) Sugar City

15.
Filed 1-26 1914 L. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1914, to Jan. 1914
that I last saw her alive on " 25 1914
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute Heart Failure
Acute dilitation of heart
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr J.R. Shayne M. D.
1/25 1914 (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar	1/28 1914

20. UNDERTAKER	ADDRESS
John P. Phillips	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 6817

County of Madison

City of Rexburg (No. ....., ... St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy D. Darkman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: August 22 1863 (Month) (Day) (Year)

7. AGE: 49 yrs. 5 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Maker
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Brackenage Co. Kentucky

10. NAME OF FATHER: James M Ray

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Victory [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Veda Stuart
(Address): Rexburg Idaho

15.
Filed 1-27 1914 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1914, to Jan 26 1914 that I last saw her alive on Jan 26 1914, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH was as follows: Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

1/26 1914 (Address) Rexburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Renton — DATE OF BURIAL: 1/28 1914

20. UNDERTAKER: [illegible] Rigney — ADDRESS: Rigney

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6820
Registered No.

1. PLACE OF DEATH. Registration District No. 53
County of Bear Lake Primary Registration District No. 2432
City of Liberty (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Jane Poulson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal W.
4. COLOR OR RACE:
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1837 (Year)

7. AGE: 76 yrs. 11 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Poulson

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Mary Humphreys

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Poulson
(Address) Liberty

15. Filed Jan 31 1914 W. H. Reich Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1914, to Jan 31 1914, that I last saw b[illegible] alive on Jan 30 1914, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH was as follows:*
Apoplexy Cerebral
Rheumatism

(Duration) yrs. mos. 10 ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Jan 31 1914 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or [illegible] residence

19. PLACE OF BURIAL OR REMOVAL: Liberty — DATE OF BURIAL: Jan 31 1914

20. UNDERTAKER: Joseph Prescott — ADDRESS: Paris Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6821

Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Lanark

Registration District No. 53
Primary Registration District No. 2132
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joanna Passey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Baby~~

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1914 (Year)

7. AGE: ....yrs. ....mos. ....ds.
IF LESS than 1 day how many ....hrs. or ....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clarence Passey

11. BIRTHPLACE OF FATHER (State or Country): Paris Idaho

12. MAIDEN NAME OF MOTHER: Joanna Brunt

13. BIRTHPLACE OF MOTHER (State or Country): Paris

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T Passey
(Address) Paris Idaho

15. Filed Jan 30 1914 W. L. Rich Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....
that I last saw h....alive on ....191....
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Premature

(Duration) ....yrs. ....mos. ....ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) E. E. Bailey M. D.
Jan 30 1914 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....ds.
In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lanark
DATE OF BURIAL: Jan 30 1914

20. UNDERTAKER: Ed P & Jo Passey
ADDRESS: Lanark Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6824
Registered No.

1. PLACE OF DEATH.
County of Lemhi
City of Leadore
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 42
Primary Registration District No. 2153

2. FULL NAME Infant of R D Davidson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH
Jan - 6" 1913
(Month) (Day) (Year)

7. AGE
1 yrs ## mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Leadon Idaho

10. NAME OF FATHER R D Davidson

11. BIRTHPLACE OF FATHER (State or Country) Cir Kansas

12. MAIDEN NAME OF MOTHER Julia McDermott

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J A McCornick
(Address) Leadon Idaho

15.
Filed Jan 11 1914 Frank O Lucas
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 5" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Lobular Pneumonia
Physician called to late
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Coroner W C Dabb
Jan 5" 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Leadore Cemetery — DATE OF BURIAL: Jan 7" 1914

20. UNDERTAKER: Geo Martin — ADDRESS: Leadore

Cuting Geo Such Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6825
Registered No.

1. PLACE OF DEATH.
County of Lemhi
City of Gilmore

Registration District No. 42
Primary Registration District No. 2163
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans Matson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): Married

6. DATE OF BIRTH: Unknown (Month) ~~Jan~~ 7 (Day) ~~1914~~ (Year)

7. AGE: 45 ? yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank O. Paulk M.D.
(Address) Gilmore, Idaho

15. Filed Jan 17 1914 Frank O. Paulk M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Jan 7 1914
that I last saw him alive on Jan 7 1914
and that death occurred on the date stated above, at 8:15 A M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank O. Paulk M. D.
Jan 8 1914 (Address) Gilmore, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gilmore, Idaho
DATE OF BURIAL: Jan 9 1914

20. UNDERTAKER: No Licenced Undertaker.
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Offord
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2 0 4 6

File No. 6834
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kate Emile Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: 29 (Month) Nov (Day) 1863 (Year)

7. AGE: 50 yrs. 1 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House & Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: John Redington

11. BIRTHPLACE OF FATHER (State or Country): Nazin Essex England

12. MAIDEN NAME OF MOTHER: Mariam Brown

13. BIRTHPLACE OF MOTHER (State or Country): Rekesford Manos Worcestor Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benj W Robinson
(Address) Offord Idaho

15. Filed June 10, 1914 Chas I Cassady
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) Jan (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1. 1912, to June 1 1912, that I last saw her alive on June 1, 1912 and that death occurred on the date stated above, at Noon.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) R Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas I Cassady M. D.
June 10 1914 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Offord
DATE OF BURIAL: Jan 5 1914

20. UNDERTAKER: No undertaker
ADDRESS: —

By Denney & Denney, acting

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6836
Registered No. 4

1. PLACE OF DEATH.
County of Bannock
City of Cleveland

Registration District No. 11
Primary Registration District No. 2048
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Smith.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Girl	white	Baby

6. DATE OF BIRTH: March (Month) 13 (Day) 1913 (Year)

7. AGE: ..... yrs. 9 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Cleveland Idaho

10. NAME OF FATHER George Albert Smith

11. BIRTHPLACE OF FATHER (State or Country) Clifton Idaho

12. MAIDEN NAME OF MOTHER Hannah Margaret Nielsen

13. BIRTHPLACE OF MOTHER (State or Country) Cleveland Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Landgreen
(Address) Treasureton Idaho

15.
Filed Jan 10, 1914 Eric Larsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Rickets from the time of Birth, being a premature Baby

(Duration) ..... yrs. 9 mos. 19 ds.
Contributory (Secondary) Premature Birth
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eric Larsen M. D.
Jan 14 1914 (Address) Lela Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cleveland Idaho
DATE OF BURIAL: Jan 4 1914

20. UNDERTAKER: B. F. Larsen
ADDRESS: Lelund

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Iona
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No.
(No. , St.)

File No. 6865
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virginia Andreasen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar. (Month) 11 (Day) 1913 (Year)

7. AGE: yrs. 11 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chris Andreasen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mark Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chris Andreasen
(Address): Iona Idaho

15. Filed Feb 7 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3 1914, to Feb. 4, 1914 that I last saw h~~im~~ alive on Feb. 3, 1914 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. 1 mos. ds.

Contributory (Secondary) Bronchopneumonia

(Duration) yrs mos. 4 ds.

(Signed) [illegible] M. D.

2/6 1914 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona Idaho
DATE OF BURIAL: 2/6 1914

20. UNDERTAKER: G H Hunt
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6869

Registered No. 7

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 72

County of Bannock

Primary Registration District No. 21 St

City of Pocatello (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph H. Madison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Nov (Month) 2 (Day) 1911 (Year)

7. AGE: 2 yrs. 3 mos. X ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John L. Madison

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Sarah C. Ballard

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. L Madison Pa. Ed
(Address) RD #1 City

15. Filed Jan 13 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1914, to Feb 2 1914, that I last saw him alive on Feb 1 1914, and that death occurred on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:
Gastritis & Enteritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. S. Fuller M. D.

2/3 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 2/4 1914

20. UNDERTAKER: C. E. Dinwoodey — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7?
Primary Registration District No. 1
File No. 6870
Registered No.

1. PLACE OF DEATH.
County of Bonneville
City of Lincoln (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Prestwich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Jan. (Month) 29 (Day) 1914 (Year)
7. AGE: still born yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or 20 mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Geo. M. Prestwich
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Ruth Mursey
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo M Prestwich
(Address) Lincoln Idaho
15.
Filed Jan 29 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 29 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191..., that I last saw h... alive on ... 191..., and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
still born
a
(Duration) ... yrs. ... mos. ... ds.
Contributory
(Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Thomas C. Wilson M. D.
Jan 29 1914 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lincoln Idaho — DATE OF BURIAL: 1/29 1914
20. UNDERTAKER: C. H. Hunt — ADDRESS: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2112

File No. 6871

County of Bonneville

City of Idaho Falls (No. ....., ... St.)

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1903 (Year)

7. AGE: 10 yrs. 11 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: W. G. Brown

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Will Finness

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Brown
(Address) Grant Idaho.

15. Filed Jan 21 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1914, to Jan 21 1914, that I last saw h[illegible] alive on Jan 20 1914 and that death occurred on the date stated above, at 1.40 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonary
Tuberculosis Enteritis

(Duration) ..... yrs. ..... mos. ✓ ds.
Contributory Tuberculosis
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
1/21 1914 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Grant Idaho. DATE OF BURIAL: 1/24 1914

20. UNDERTAKER: G. H. Hunt ADDRESS: G. H. Hunt [illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SMMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 73
County of Bonneville Primary Registration District No. [illegible]
City of Idaho Falls (No. ....., ... St.)
File No. 6872
Registered No. 4
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elvie Oakden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH: Feby (Month) 21 (Day) 1913 (Year)

7. AGE: ..... yrs. 10 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Phillip L Oakden

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Edith Jacobson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phillip Oakden — D.
(Address) Irwin Ida

15. Filed Jan 16 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Janry (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1913, to Jan 14 1914, that I last saw h[illegible] alive on Jan 14 1914, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Gastritis duturtis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. S. Fuller M. D.
Jan 14 1914 (Address) Ft. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Irwin Idaho — DATE OF BURIAL: 1/17 1914

20. UNDERTAKER: E. E. Dinwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2181-9

File No. 6873
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Sloo Farr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May 16 1863 (Month) (Day) (Year)

7. AGE: 51 yrs. 7 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Sloo Farr

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Farr
(Address) Idaho Falls Ida

15. Filed Jan 6 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 6 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191..., that I last saw h ✓ alive on ✓ 191..., and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Myocarditis
(Heart failure)
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
1/6 1914 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah
DATE OF BURIAL: Stopped 191...

20. UNDERTAKER: G W Hunt
ADDRESS: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..... St.)

Registration District No. 7
Primary Registration District No. 1

File No. 6874
Registered No. -

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barbara Haderlie

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ~~March~~ May 23 1913
(Month) (Day) (Year)

7. AGE: ..... yrs. 7-9 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bowdy Rec Ind

10. NAME OF FATHER: David J Haderlie

11. BIRTHPLACE OF FATHER (State or Country): Providence Utah

12. MAIDEN NAME OF MOTHER: Mary Price

13. BIRTHPLACE OF MOTHER (State or Country): Doral Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. W. Haderlie
(Address) [redacted] Idaho

15.
Filed Jan 3 1913 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1912, to Jan 1 1913, that I last saw her alive on Jan 1 1913, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Nephritis acute
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Fuller M. D.
Jan 3 1913 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ucon Idaho
DATE OF BURIAL: Jan. 4 1913

20. UNDERTAKER: G. H. Hunt
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6876
Registered No.

1. PLACE OF DEATH.
County of Ida
City of Pallock

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claud Snyder

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January 30 1866
Lang

7. AGE: 47 yrs. 11 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): East Worcester Ny

10. NAME OF FATHER: Egbert Snyder

11. BIRTHPLACE OF FATHER (State or Country): East Worcester Ny

12. MAIDEN NAME OF MOTHER: Celia La Monte

13. BIRTHPLACE OF MOTHER (State or Country): Worcester Ny

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Egbert Snyder
(Address) East Worcester Otsego Co Ny

15.
Filed ..... 191...
W A Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1913, to Jan 8, 1914
that I last saw h alive on Jan 8 1913
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Septicaemia following a large Carbuncle over the Sacrum
(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W A Foskett M. D.
Jan 2 1914 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: East Worcester
DATE OF BURIAL ..... 191...

20. UNDERTAKER: L C Northam
ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2687

1. PLACE OF DEATH.
County of Blaine
City of Moore
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

2. FULL NAME Mrs Ellen Barr

Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May 18 (Month) (Day) 1889 (Year)

7. AGE: 24 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Abel Swanson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Charlotte Burstedt

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jay Barr
(Address) Moore, Idaho

15.
Filed 1-20 1914 Lee Fox
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1914, to Jan 18 1914
that I last saw her alive on Jan 18 1914,
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Acute Miliary Tuberculosis

2 wks (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Lobar Pneumonia
2 wks (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lee Fox M. D.
1/20 1914 (Address) Moore - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moore, Idaho
DATE OF BURIAL: Jan 20 1914
20. UNDERTAKER
ADDRESS

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Ames
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

File No. 6878
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Frank Fredrick Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 2 (Day) 1875 (Year)

7. AGE: 37 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Paris County, Utah

10. NAME OF FATHER: David Sessions Brown

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Abbie A. Flagg

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Brown
(Address) Ames, Idaho

15. Filed 1-27 1914 Ewtoy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1914, to Jan 26 1914, that I last saw him alive on Jan 26 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Relapse)
Duration ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Cardiac insufficiency
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ewtoy M. D.
1-27 1914 (Address) Ames, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Blackfoot, Ida
DATE OF ~~BURIAL~~ Removal 1-27 1914

20. UNDERTAKER: E. J. Peck
ADDRESS: Blackfoot, Ida

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6879
Registered No. 8

1. PLACE OF DEATH.
County of Bingham
City of Sterling
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116
Primary Registration District No. 2195
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Bertha Reichert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Oct (Month) 27 (Day) 1849 (Year)

7. AGE: 64 yrs. 2 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Henry Hymis

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dorothea Thom

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Reichert
(Address) Sterling Ida

15. Filed Jan 25 1914 M.C. Mackinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1914, to Jan 23 1914
that I last saw h[illegible] alive on Jan 23 1914
and that death occurred on the date stated above, at 7[illegible] P.M.

The CAUSE OF DEATH* was as follows:
Goitre

..... (Duration) 1 yrs. — mos. — ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. C. Mackinnon M. D.
Jan 25 1914 (Address) Aberdeen, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello, Ida.
DATE OF BURIAL: Jan 27 1914

20. UNDERTAKER: Will T. Walker
ADDRESS: Pocatello, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)

Registration District No. 61
Primary Registration District No. 1011

File No. 6880
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Vosburgh

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Jan (Month) 6 (Day) 1875 (Year)

7. AGE: 39 yrs. 39 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida[illegible]

10. NAME OF FATHER: N A Vosburgh

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary E Griffith

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J E Vosburgh
(Address) Moscow Idaho

15. Filed Jan 18 1914 — J F Rae, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Jan 16 1914
that I last saw h[illegible] alive on Jan 15 1914
and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

..... (Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Caspar M. D.
Jan 16 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: Jan 18 1914

20. UNDERTAKER: Geo Gleltz
ADDRESS: moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 61
County of Latah Primary Registration District No. 1011
City of Moscow (No. ....., ... St.)
File No. 6881
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec. (Month) 28 (Day) 1913 (Year)

7. AGE: ..... yrs. ..... mos. 7 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow

10. NAME OF FATHER: Frank C Christenson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Carrie Gemmeke

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Christenson
(Address) moscow

15.
Filed Jan 5 1914 D F Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw her alive on Dec 27 1913
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Clarke M. D.
..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: Jan 4 1914

20. UNDERTAKER: None
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. ~~2~~ 1011
File No. 6882
Registered No. 1

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Almira Beddall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fm
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: March (Month) 5 (Day) 1839 (Year)

7. AGE: 74 yrs. 10 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or 30 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James Sperry

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: ~~Jackson~~

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. M. Beddall
(Address) Spokane, Wash

15. Filed Jan 12 1914 J. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1914 to Jan 11 1914, that I last saw her alive on Jan 10 1914, and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:
Gallstone and Senility

(Duration) 6 mos. yrs. mos. ds.
Contributory Gallstone
(Secondary)
(Duration) 10 yrs. mos. ds.

(Signed) W. A. Cleaver M. D.
Jan 12 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Wisconsin
DATE OF BURIAL: Shipped to town 191..

20. UNDERTAKER: Nelson Stiff
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BDRS. 19760

16

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6883
Registered No. 9

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. [illegible], [illegible] St.)

Registration District No. 61
Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter John Pearson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 17 (Day) 1838 (Year)

7. AGE: 75 yrs. 4 mos. 8 ds.
IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dairyman (Retired)
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: P. J. Pearson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. L. Pearson
(Address) Moscow

15. Filed Jan 26 1914 — J. F. Rae, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17 — 1913, to Jan 26 — 1914 that I last saw h[illegible] alive on Jan 24 — 1914 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) — yrs. 7 mos. 1 ds.

Contributory (Secondary) Chronic Rheumatism

(Duration) 16 yrs. 6 mos. ds.

(Signed) J. C. Wirk M. D.

Jan 25 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Jan 27 1914

20. UNDERTAKER: Geo Stitz — ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 2141
(No. ....., ... St.)

File No. 6884
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virgie B. Pierce

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug (Month) 5 (Day) 1911 (Year)

7. AGE: 2 yrs. 5 mos. 2 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Pierce

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Pierce
(Address) Deary

15. Filed Jan 7 1914 — D. F. Rae, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Supposed Dysentery
was dead when I
arrived

..... (Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Texas Ridge — DATE OF BURIAL: Jan 8 1914

20. UNDERTAKER: none — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 214
File No. 6885
Registered No. 3

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christian Sears

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 5 (Day) 1827 (Year)

7. AGE: 87 yrs. 8 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: dont Know

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W.M Sears
(Address): Troy Ida

15. Filed Jan 19 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1913, to Jan 18 1914, that I last saw him alive on Oct 25 1913, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. 6 mos. ds.

Contributory (Secondary) none

(Duration) yrs. mos. ds.

(Signed) W. A. Cobb M. D.

Jan 19 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bethel Church — DATE OF BURIAL: Jan 20 1914

20. UNDERTAKER: W M Sears — ADDRESS: Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 6887
Registered No. 3

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Snow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	white	

6. DATE OF BIRTH: Nov. (Month) 22 (Day) 1913 (Year)

7. AGE: ..... yrs. [illegible] mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moscow Idaho

10. NAME OF FATHER: I. E. Snow

11. BIRTHPLACE OF FATHER (State or Country): Moscow Idaho

12. MAIDEN NAME OF MOTHER: Etta Berry

13. BIRTHPLACE OF MOTHER (State or Country): Avon Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Snow
(Address) Moscow Idaho

15. Filed Jan 13 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1914 to Jan 12 1914, that I last saw h[illegible] alive on Jan 12 1914 and that death occurred on the date stated above, at 8 10 M.

The CAUSE OF DEATH* was as follows:
Congestion of lungs
due to open pneumonia
ovale Top of heart.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Hatfield M.D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Jan 14 1914

20. UNDERTAKER: [illegible] — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Idaho

WASHINGTON STATE BOARD OF HEALTH

Primary

Record No. 61 & 2141

File No. 6888

Registered No. 8

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Latah

City or Town of Viola Idaho

Registration Dist. No. ..... (No. ....., ... St.; ..... Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]

Full Name Orpha Gertrude Lynch

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH: June (Month) 20th (Day), 1911 (Year)

7 AGE: 2 yrs. 6 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... mln.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Viola Idaho

PARENTS

10 NAME OF FATHER J R Lynch

11 BIRTHPLACE OF FATHER (State or country) Colfax Wash

12 MAIDEN NAME OF MOTHER Viola Kenney

13 BIRTHPLACE OF MOTHER (State or country) Dayton Wash

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J R Lynch

(Address) .....

15 Filed Jan 22, 1914 F F Rae REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 5th (Day) 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1913, to Jan 4th, 1914, that I last saw h alive on Jan 4th, 1914, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Injury & Shock

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Canfield D.O.

191.... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Viola Idaho

DATE OF BURIAL: Jan 6th 1914

20 UNDERTAKER: C L Shaw Gertrude Stinson

ADDRESS: Colfax Wash Idaho License #59

Buried with Burial permit

Duplicates in Lands

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V.S. No. 1

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Burke
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39
Primary Registration District No. 2087
(No. ....., ... St.)

File No. 6890
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin F. White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M.	White	

6. DATE OF BIRTH: Feb (Month) 7 (Day) 1849 (Year)

7. AGE: 64 yrs. 10 mos. 24 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Wm White

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Mary Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Myer
(Address) Burke

15. Filed 1-2 1913 J. Thornley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1913, to Jan 1 1914, that I last saw h in alive on Jan 1 1914, and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:
Apoplexy

..... (Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Wilhelmi M. D.
Jan 2 1914 (Address) Burke Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: June 3 1913

20. UNDERTAKER: H. P. Evans — ADDRESS: Burke Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39
Primary Registration District No. 2087

File No. 6891
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herbert Leicester Reeves

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH: Feb. (Month) 28th (Day) 1907 (Year)

7. AGE: 6 yrs. 10 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Atchison Kans

10. NAME OF FATHER: Frank Reeves Jr.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Myrtle McClelland

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. Reeves
(Address) Buhl Ida

15.
Filed 1-5 1914 J. Murphy
Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 19760

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 4th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24 1913, to Jan 4 1914, that I last saw h in alive on Jan 4 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Diabetes mellitus

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Wetherbee M. D.
Jan 5 1914 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl — DATE OF BURIAL: 1-6 1914

20. UNDERTAKER: W. J. Evans — ADDRESS: Buhl, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2087
File No. 6892
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burke
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Van Hamby
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: July 22 1887
(Month) (Day) (Year)

7. AGE: 31 yrs. 5 mos. 14 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee.

10. NAME OF FATHER: Geo Spartman

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Minnie Van Spartman

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Hamby
(Address) Burke.

15. Filed 1-6. 1914 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1913, to Jan 5 1914, that I last saw her alive on Jan 5 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Part pain from Hemorrhage following miscarriage at 5 mo.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Placenta Previa
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. T. McClusky M. D.
Jan 5 1914 (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Idaho. DATE OF BURIAL: Jan 7 1914

20. UNDERTAKER: A. B. Evans ADDRESS: Burke Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

69

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39.
Primary Registration District No. 2087
(No. ....., ... St.)

File No. 6893
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Annie Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F	W.	

6. DATE OF BIRTH: May (Month) 22 (Day) 1844 (Year)

7. AGE: 69 yrs. 7 mos. 18 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Jörgen Petersen

11. BIRTHPLACE OF FATHER. (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Karen Petersen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. R. M. Cruse
(Address) Burley Ida

15.
Filed 1-10 1914 J. Thornley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 9 (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Paralysis of Heart.
about 10 days
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Thornley M. D.
1-10 1914 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Burley | DATE OF BURIAL: 1-12 1914

20. UNDERTAKER: H. B. Evans | ADDRESS: Burley

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No. ....., ... St.)

File No. 6894
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Heston Moore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH Jan 1 1856
(Month) (Day) (Year)

7. AGE 58 yrs. ..... mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Lumberman
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Benjaman Moore

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Hannah Harlan

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E Moore
(Address) .....

15.
Filed 1-16 1914
J. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 15 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1913, to Jan 15 1914.
that I last saw him alive on Jan 15 1914
and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
General Paralysis.

..... (Duration) 1 yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Murphy M. D.
1-16. 1914 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Buhl Ida
DATE OF BURIAL 1-18 1914

20. UNDERTAKER H. B. Evans
ADDRESS Buhl.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
(No. ....., ... St.)

Registration District No. 38
Primary Registration District No. 2086

File No. 6896
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Young

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 9 (Month) (Day) 1888 (Year)

7. AGE: 25 yrs. 6 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah Garfield Co

10. NAME OF FATHER: William Wellis Young

11. BIRTHPLACE OF FATHER (State or Country): Utah Utah Co.

12. MAIDEN NAME OF MOTHER: Harriet Ann Pierce

13. BIRTHPLACE OF MOTHER (State or Country): Utah Washington Wash Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wellis Young
(Address) Helena Mont

15. Filed Jan 15 1914 A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1914, to Jan 13 1914 that I last saw him alive on Jan 13 1914 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Not known

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A Newberry M. D.

Jan 14 1914 (Address) Filer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho
DATE OF BURIAL: Jan 15 1914

20. UNDERTAKER: R. J. Foreman
ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6897

Registered No. 2

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

(No. ....., ... St.)

Registration District No. 126

Primary Registration District No. 2204

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Burnice Louis Burton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 13 (Day) 1914 (Year)

7. AGE: .....Yrs. .....Mos. 18 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. G. Burton

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Beatrice Keat

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. G. Burton

(Address) Harrison Ida

15. Filed Feb 5 1914

R. S. Jensen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1914, to Jan 31 1914, that I last saw h[illegible] alive on Jan 31, 1914, and that death occured on the date stated above, at 12 30 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

.....(Duration) .....Yrs. .....mos. 18 ds.

Contributory (Secondary) Premature birth

.....(Duration .....yrs. .....mos. .....ds.

(Signed) C. L. Regen M. D.

Feb 1 1914 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....da

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: Feb 1 1914

20. UNDERTAKER: C. G. Burton — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6898
Registered No. 1

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

Registration District No. 128
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~ Single

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1914 (Year)

7. AGE: ~~4 hours~~ yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 4 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry business or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Kootenai Co. Idaho

10. NAME OF FATHER: John M. Finney

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Gertrude Bridgman

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. M. Finney
(Address) Harrison Idaho

15. Filed Jan 3 1914 R.S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw him alive on Jan 2 1914
and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Postular Gangrene Ovale.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. M. Finney M. D.
Jan 3 1914 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison
DATE OF BURIAL: 1-3 1914

20. UNDERTAKER: Evans Heeden
ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6899

Registered No. 3

1. PLACE OF DEATH.

County of Kootenai

City of Rose Lake

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 126

Primary Registration District No. 2204

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nick Nickerson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't Know

6. DATE OF BIRTH. Don't Know (Month) (Day) 1 (Year)

7. AGE: believed to be 56 to 58 yrs ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Cutting Wood

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. E. Workmaster

(Address) Rose Lake Ida

15.

Filed ..... 191....

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Believed to be January 17 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Sunday Jan 8 1914, to ..... 191..., that I last saw him alive on ..... a month or more before ..... 191..., and that death occured on the date stated above, at Jan 17 1914 M.

The CAUSE OF DEATH* was as follows: Primary Senility - Mal-Nutrition and Exhaustion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Workmaster M. D.

19.... (Address) Rose Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. 6 days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: 3 miles North Rose Lake — DATE OF BURIAL: Jan 20 1914

20. UNDERTAKER: E. W. Wheeler — ADDRESS: Harrison

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6900
Registered No. 4

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

Registration District No. 124
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charles Harry Moore.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1914 (Year)

7. AGE: ..... yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: ×
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Harrison Idaho.

10. NAME OF FATHER: Ray Moore.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Lucy Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray E. Moore.
(Address) Harrison, Idaho.

15. Filed Feb 6 1914 R.S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1914, to Feb 3 1914
that I last saw him alive on Feb. 3 1914
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia.

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Fleming M. D.
Feb 3 1914 (Address) Harrison Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison
DATE OF BURIAL: Feb 4 1914

20. UNDERTAKER: E. W. Keller
ADDRESS: Harrison Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: *(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

9 # 2

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6901
Registered No. 1

1. PLACE OF DEATH.
Registration District No. 92
County of Fremont
Primary Registration District No. 2170
City of Gifford (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Coatney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W	widowed

6. DATE OF BIRTH
Nov 3 1826
(Month) (Day) (Year)

7. AGE
87 yrs. 1 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Va

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Coatney
(Address) Gifford

15.
Filed 1 — 1 1914
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan 1 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1913, to ——— 191—
that I last saw her alive on Dec 29 1913
and that death occurred on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:
Senile decay

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.
1 — 1 1914 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Melrose	1 — 2 1914

20. UNDERTAKER	ADDRESS
W. E. Stoddard	Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6902
Registered No. 21

1. PLACE OF DEATH.
County of Nez Perce
City of Gifford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Geo W Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	married

6. DATE OF BIRTH: Dec (Month) 11 (Day) 1857 (Year)

7. AGE: 62 yrs. 1 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Caleb Brown

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Isabella Stinnett

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia Brown
(Address)

15. Filed 1-26 1914 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1914, to Jan 25 1914, that I last saw him alive on Jan 25 1914 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Hepatic Abscess

(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.
1-26 1914 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Myrtle — DATE OF BURIAL: 1-28 1914

20. UNDERTAKER: W. E. Goddard — ADDRESS: Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6903
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2011
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thomas Whiteside

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: Mar (Month) 21 (Day) 1869 (Year)

7. AGE: 44 yrs. 9 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Edward Whiteside

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ellen Banner

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Thos. Whiteside
(Address) Emmett Idaho

15.
Filed 1-30 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1914, to Jan 16 1914, that I last saw him alive on Jan 14 1914, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 12 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.
1-31 1914 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery | DATE OF BURIAL: Jan 18 1914

20. UNDERTAKER: C. S. Buckner | ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 6903

Name Thomas Whiteside

Date of Death Jan. 16, 1914

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) J. T. Reynolds M.D.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1014
County of Gooding Primary Registration District No. 2014
City of Gooding (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 6906
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Minnie A Dickerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 4 (Day) 1872 (Year)

7. AGE: 41 yrs. 3 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Conrad Ebert

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Josephine Ebert
Minnie A Eb

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P B Dickerson
(Address) Gooding Idaho

15.
Filed 1-24 191[illegible] F J Hay
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-13- 1914, to Jan-23rd 1914
that I last saw her alive on Jan 22 1914
and that death occurred on the date stated above, at 11.9 M

The CAUSE OF DEATH* was as follows:
Valvular Valvitus —
Endocarditis, complicated by Rheumatism
(Duration) ..... yrs. ..... mos. ..... ds

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds

(Signed) F. F. Hay md M. D.
1-24 1914 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho — DATE OF BURIAL: 1-26 1914

20. UNDERTAKER: V E Thompson — ADDRESS: Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6907
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Garfield

Registration District No. 65.
Primary Registration District No. 2145.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Anna Katrina Clausen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	

6. DATE OF BIRTH: Aug. (Month) 1 (Day) 1906 (Year)

7. AGE: 7 yrs. 6 mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Rasmus Clausen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Maren Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rasmus Clausen
(Address) Garfield. Wash.

15. Filed Feb 3 1914 — J. W. Thomson — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1st 1914, to Feb 1st 1914 that I last saw her alive on Feb. 1st 191 and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Convulsions.

..... (Duration) ..... yrs. ..... mos. ./. ds.
Contributory (Secondary) Auto intoxication from intestinal derangement.
..... (Duration) ..... yrs. ..... mos. ./. ds.

(Signed) J. W. Thomson M. D.
Feb. 2 1914 (Address) Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fraser, Idaho	Feb. 3. 1914
20. UNDERTAKER	**ADDRESS**
F. L. Irwin	Garfield, Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6908

Registered No.

1. PLACE OF DEATH.

County of Latah.

City of Potlatch

Registration District No. 65.

Primary Registration District No. 2145.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maggie Matilda Brotan.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: white.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Jan. (Month) 13 (Day) 1865. (Year)

7. AGE: 49 yrs. ✓ mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania.

10. NAME OF FATHER: Christopher Jackman

11. BIRTHPLACE OF FATHER (State or Country): France.

12. MAIDEN NAME OF MOTHER: Mar Kuown (Duggan)

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. G. Brotan.
(Address) Garfield Wash.

15.
Filed Jan. 30 1914. Dr. J.R. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 30 (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1913, to Jan 28 1914
that I last saw her alive on Jan 28 1914
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. J.R. Thompson M. D.
Jan 30 1914 (Address) Potlatch Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery
DATE OF BURIAL: Feb 2nd 1914

20. UNDERTAKER: ~~Name~~ - Parents
ADDRESS: Garfield Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6909
Registered No.

1. PLACE OF DEATH.
County of Latah.
City of Potlatch.
(No. ....., ... St.)

Registration District No. 65.
Primary Registration District No. 2145.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theodore Albert Runeberg.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: Caucasian.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. 13. 1913.
(Month) (Day) (Year)

7. AGE: ..... yrs. 2 mos. 12. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Daniel Theodore Runeberg.

11. BIRTHPLACE OF FATHER (State or Country): Sweeden.

12. MAIDEN NAME OF MOTHER: Martha Norberg.

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel T. Runeberg.
(Address) Potlatch

15.
Filed Jan 27 1914. D. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 27 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 1913., to Jan. 25th 1914.
that I last saw him alive on Jan. 25th 1914
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Marasmus.

..... (Duration) ..... yrs. 2. mos. ..... ds.
Contributory (Secondary): Laryngo-Stenosis.
..... (Duration) ..... yrs. 2 mos. ..... ds.
(Signed) J. W. Thompson M. D.
Jan 27 1914 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery
DATE OF BURIAL: Jan. 28 1914

20. UNDERTAKER: Parents.
ADDRESS: Potlatch.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 42
County of Lemhi Primary Registration District No. 2153
City of Leadore (No. ....., ... St.)
File No. 6910
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Jackson Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Do not know ..... 1 ..... (Month) (Day) (Year)

7. AGE: 64 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher & Telephoning
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Memphis Missouria

10. NAME OF FATHER: Ned Smith

11. BIRTHPLACE OF FATHER (State or Country): Missouria

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Chas Robertson
(Address) Leadore Ida

15. Filed Dec 2 1914 Frank O. Paul M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 28 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1914, to Jan 28 1914, that I last saw h in alive on Jan 28 1914, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Hamme M. D.

1/9 1914. (Address) Leadore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Leadore Cemetery — DATE OF BURIAL: Jan 30" 1914

20. UNDERTAKER: W. C. Keeler — ADDRESS: Salmon Ida,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 6911

Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Green Creek (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183

2. FULL NAME Joseph Ahlers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: August (Month) 9 (Day) 1864 (Year)

7. AGE: 49 yrs. 6 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank J Ruxoll
(Address) Green Creek Ida

15.
Filed Jany 19 1914 H B Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 19th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ at various times during the past 5 years 191 , to 191 , that I last saw him alive on about Jan 5th 1914, and that death occurred on the date stated above, at 9. a M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease.
Probably 12 or 15 years
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. W. Turner, M. D.
1-19- 1914 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Catholic Cemetery Green Creek Idaho
DATE OF BURIAL: Jany 21 1914

20. UNDERTAKER: F T Barbour
ADDRESS: Green Creek Ida

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

File No. 2 6912

Registered No.

County of Idaho

City of Cottonwood (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myron J. Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

June (Month) 20 (Day) 1865 (Year)

7. AGE

48 yrs. 7 mos. 6 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Day Laborer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Webster City, Iowa.

10. NAME OF FATHER R. H. Butler

11. BIRTHPLACE OF FATHER (State or Country) Brownsville, Penn.

12. MAIDEN NAME OF MOTHER Mary A. Lyon.

13. BIRTHPLACE OF MOTHER (State or Country) Georgetown, Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary A. Butler

(Address) Cottonwood, Idaho

15.

Filed Jany 29 1914 H B Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1913, to Jan 25 1914, that I last saw h. liv alive on Jan 25 1914, and that death occurred on the date stated above, at 12:45 M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
due to Chronic Parenchymatous
Nephritis - Duration Unknown.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Kelly B.A. Orr, M. D.

1-27 1914 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Idaho | DATE OF BURIAL: Jan. 28 1914

20. UNDERTAKER: Henry McVicar | ADDRESS: Cottonwood Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6913
Registered No.

1. PLACE OF DEATH
County of Washington
City of Cambridge
Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Struckman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) (Day) 1848 (Year)

7. AGE: 56 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tramp
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: John H Struckman

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Anna Mussy

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Schmuntz
(Address) Cambridge Idaho

15. Filed Jan 17 1914 C E Schmuntz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Jan 16 1914
that I last saw him alive on Jan 13 1914
and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

..... (Duration) 3 yrs. 6 mos. 10 ds.
Contributory (Secondary) Influenza
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Schmuntz M. D.
Jan 16 1914 (Address) Cambridge Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho
DATE OF BURIAL: Jan 16 1914

20. UNDERTAKER: Jas Hendelson
ADDRESS: Cambridge Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 852

Primary Registration District No. 2164

File No. 6914

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Cambridge (No. 12 miles S.E. Cambridge)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Louisa Mulkey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: July (Month) — 10 (Day) 1834 (Year)

7. AGE: 80 yrs. 6 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of Missouri

10. NAME OF FATHER: Philip Cantrell

11. BIRTHPLACE OF FATHER (State or Country): State of Missouri

12. MAIDEN NAME OF MOTHER: Polly Richie

13. BIRTHPLACE OF MOTHER (State or Country): State of Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Honig

(Address) Cambridge Ida

15.

Filed Jan 13 1914 C E Schunk
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) — 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1913, to Jan 11 1914, that I last saw her alive on Dec 5 1913, and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. 3 mos. ds.

Contributory (Secondary) old age

(Duration) yrs. mos. ds.

(Signed) Simeon Hopper M. D.

19 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Eugene Oregon — DATE OF BURIAL: Jan 16 1913

20. UNDERTAKER: J. W. Bowen — ADDRESS: Weiser Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Cambridge.
(No. ....., ... St.)

Registration District No. 88
Primary Registration District No. 2164

File No. 6915
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B Nolan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1837 (Year)

7. AGE: 77 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranching
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: William Nolan

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Katherine Davis

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr C E Schmuntz
(Address) Cambridge Idaho

15. Filed Feb 8 1914 C E Schmuntz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1910, to Feb 5 1914
that I last saw him alive on Feb 5 1914
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Paralysis General

..... (Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Schmuntz M. D.
Feb 10 1914 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho
DATE OF BURIAL: Feb 6 1914

20. UNDERTAKER: Jas Hudelson
ADDRESS: Cambridge Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No. 254
File No. 6916
Registered No. .....

1. PLACE OF DEATH.

County of Washington
City of Midvale.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bell L. Stewart.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W Lite,

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June. (Month) 19 (Day) 1889 (Year)

7. AGE: 24 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho. Washington Co.

10. NAME OF FATHER: R. Shirts.

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lizzie Stephens
(Address) Midvale Idaho.

15. Filed Jan 22 1914 Houston E Snyder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1914, to Jan 20 1914, that I last saw her alive on Jan 20th 1914, and that death occured on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Strychnine Poisoning

(Duration) ..... Yrs. ..... mos. 1½ ds.

Contributory (Secondary) Pneumonia.

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Houston E Snyder M. D.

Jan 22 1914 (Address) Midvale Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge. DATE OF BURIAL: .....191.....

20. UNDERTAKER: Jas Huddleson ADDRESS: Cambridge Ida

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6917

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Parma

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jonathan H. Reavis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May (Month) 26 (Day) 1832 (Year)

7. AGE: 81 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Morgan Reaves

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C B Ross

(Address) Parma Idaho

15. Filed Feb 4 — 1914 — Faschnitz — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3 1914, to Feb 3 1914, that I last saw him alive on Feb 3 1914, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Exhaustion from operation on prostate gland

..... (Duration) Short time Yrs. ..... mos. ..... ds.

Contributory (Secondary) Old age

..... (Duration) Short time yrs. ..... mos. ..... ds.

(Signed) William R Bullard M. D.

Feb 4 1914 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: 2/7 1914

20. UNDERTAKER: F. R. Robinson — ADDRESS: Nampa Ida

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 81
County of Bonner Primary Registration District No. 2138
City of Priest River Ida (No. ....., ... St.)
File No. 6919
Registered No. 1
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charity Anne McWilliams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Sept (Month) 7th (Day) 1850 (Year)

7. AGE: 63 yrs. 4 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kingston. Canada

10. NAME OF FATHER: William Rose

11. BIRTHPLACE OF FATHER (State or Country): not Known

12. MAIDEN NAME OF MOTHER: Esther Ball

13. BIRTHPLACE OF MOTHER (State or Country): not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fredk W Dodier
(Address) Priest River Ida

15.
Filed Jan 30 1913 E Summerly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 29th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 20 1913, to Jany 29 1914 that I last saw her alive on Jany 28 1914, and that death occurred on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:
Asthema (Pernicious Anaemia)

(Duration) ..... yrs. 1 mos. 14 ds.
Contributory (Secondary) Neurotic predisposition
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fredk W Dodier M. D.
Jany 29 1914 (Address) Priest River Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER: Mrs R A Underwood Priest River
ADDRESS: Friend Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6920
Registered No. 1

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 1007
(No. James Add. Lincoln St.)

2. FULL NAME Thorton Patton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Dec (Month) 20 (Day) 1910 (Year)

7. AGE: 3 Yrs. 0 Mos. 10 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Francis Leroy Patton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Ballard

13. BIRTHPLACE OF MOTHER (State or Country): Arizona

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John S Patten
(Address) Blackfoot Idaho

15. Filed Jan 1 1914 — M E Patrick, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1913, to Jan 1 1914, that I last saw him alive on Dec 28 1913, and that death occured on the date stated above, at 5a. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
Right side
(Duration) Yrs. mos. 8 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. E. Patrick M. D.
1-1 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Green City Cem. Blackfoot — DATE OF BURIAL: Jan 2 1914

20. UNDERTAKER: John S Patten — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & SOBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 2194

City of Blackfoot

(No. South 2 Idaho Santasam St.)

File No. 6921

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A. Kesler

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January 8th 1914 (Month) (Day) (Year)

7. AGE: 59 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Flagman
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Ashe
(Address) Blackfoot

15. Filed Jan. 8th 1914 M. C. Talbot Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 8th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 4th 1914, to Jany 8th 1914, that I last saw him alive on Jany 8th 1914, and that death occurred on the date stated above, at 9-a M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary) Arterial Sclerosis

(Duration) Don't Know yrs. mos. ds.

(Signed) Geo. Ashe M. D.

Jan 8th 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 4 days. In the State 23 yrs. — mos. — days.

Where was disease contracted if not at place of death? Pocatello

Former or usual residence Pocatello —

19. PLACE OF BURIAL OR REMOVAL: Pocatello | DATE OF BURIAL 191

20. UNDERTAKER: E J Peck | ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1007
(No. 295 S. Maple St.)
File No. 6922
Registered No. 3.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence Curtis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1903 (Year)

7. AGE: 10 yrs. 3 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lived at home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm. E. Curtis

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mercy Miles

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B Davis Jr
(Address) Blackfoot Ida

15. Filed Jan 10 1914 W. E. Tabor Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jany (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to Jany 10 1914, that I last saw him alive on Jany 9 1914, and that death occurred on the date stated above, at 4 10 a. M.

The CAUSE OF DEATH* was as follows:
Diabetes Mell.
(Duration) — yrs. 6 mos. — ds.
Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B Davis M. D.
(Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Maryland — DATE OF BURIAL: Jan 11 1914
20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 6925
Registered No. 1

1. PLACE OF DEATH.
County of Bingham
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriett McCauley
If death occured in a hospital or institution or camp, give NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
January (Month) 26 (Day) 1882 (Year)

7. AGE
31 yrs. 11 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Colorado

10. NAME OF FATHER Wm Abercrombie

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER Vaughn

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. B. McCauley
(Address) Blackfoot R F D 3

15. Filed Jan'y 12" 1914 W. E. Pettit Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 11 (Day)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.., to ..... that I last saw h.. alive on ..... and that death occurred on the date stated above, at ....

The CAUSE OF DEATH* was as follows:
Strangulation due to pressure from enlarged Bronchial (contributed) Bronchitis
(Duration) 12 yrs. ..... mos. .....

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Davis M. D.
19.. (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL | DATE OF BURIAL
American Falls Idaho | .....191..

20. UNDERTAKER E. F. Peck | ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 6924
Registered No. 8

1. PLACE OF DEATH.
County of Bingham
~~City of~~ Thomas Precinct
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ronald Parsons Felsted

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Sept (Month) 22 (Day) 1913 (Year)

7. AGE ..... Yrs. 3 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Bingham Co. Idaho

10. NAME OF FATHER Peter C. Felsted

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Martha Parsons

13. BIRTHPLACE OF MOTHER (State or Country) Ut Tah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P P Packwell
(Address) .....

15. Filed Jan. 14 1914 — D. G. Rice, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 13th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Bronchs Pneumonea
.....(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) La grippe.
.....(Duration) ..... yrs. ..... mos. 28 ds.
(Signed) W. E. Burris M. D.
1-14 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Riverside Thomas Cem. — DATE OF BURIAL Jan 15 1914

20. UNDERTAKER P P Packwell — ADDRESS Blackfoot.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. .....) ..... St.)

File No. 6925
Registered No. 6

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Henry Price Jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 10 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bingham

10. NAME OF FATHER Charles Henry Price

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Lizzie Leora Jones

13. BIRTHPLACE OF MOTHER (State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Henry Price Sr
(Address) Blackfoot Idaho

15. Filed January 16 1914 — W E Price, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1914, to Jan 14 1914, that I last saw him alive on Jan 13 1914, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Inanition
..... (Duration) — Yrs. — mos. 4 ds.
Contributory (Secondary) Small and weak when born
..... (Duration — yrs. — mos. — ds.

(Signed) C. W. Beck M. D.
Jan 15 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mr Price's Homestead Thomas — DATE OF BURIAL: Jan 15 1914
20. UNDERTAKER: Charles Price — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6926
Registered No. 7

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1007
(No. 9, St.)

2. FULL NAME George F. Thatcher

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucassian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 7th (Day) 1871 (Year)

7. AGE: 42 yrs. 6 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Banker
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan, Utah

10. NAME OF FATHER: Moses Thatcher

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Letitia Farr

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. F. Thatcher
(Address) Blackfoot, Idaho

15. Filed Jan 18 1914 M. E. Parkin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 17th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 16 1914, to Jany 17 1914, that I last saw h im alive on Jany 17th 1914 and that death occurred on the date stated above, at 10-30 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Don't Know yrs. mos. ds.

Contributory (Secondary) Don't Know

(Duration) Don't Know yrs. mos. ds.

(Signed) Geo F Thatcher M. D.

Jany 18 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Logan Utah
DATE OF BURIAL: Jan 191

20. UNDERTAKER: E J Funk
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19765

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham — Registration District No. 121

City of Maitland — Primary Registration District No. 2194

(No. ....., ... St.)

File No. 6927

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorena Ivy Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 4 (Day) 1914 (Year)

7. AGE: Yrs. 10 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bingham Co Idaho

10. NAME OF FATHER: David Benson

11. BIRTHPLACE OF FATHER (State or Country): Utah Co Utah

12. MAIDEN NAME OF MOTHER: Bertha M Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Baughan Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David A Benson
(Address) .....

15. Filed Jan. 19 1914 — M. C. Peterson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1914, to Jan 18 1914, that I last saw her alive on Jan 18 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Mitchell M. D.

Jan 19 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groveland — DATE OF BURIAL: Jan 20 1914

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 6928
Registered No. 9

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. Idaho Insane Asylum)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oel S Cleveland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan 8 (Month) (Day) 1852 (Year)

7. AGE: 62 yrs. mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chelsea Ver

10. NAME OF FATHER: Lovel Cleveland

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Hanna Wakefield

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Jany 30 1914 W. E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 30 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 20 1914, to Jany 30 1914, that I last saw h in alive on Jany 30 1914 and that death occurred on the date stated above, at 2-45 PM

The CAUSE OF DEATH* was as follows:

Paresis

(Duration) Dont Know yrs. mos. ds.

Contributory (Secondary) Dont Know

(Duration) Dont Know yrs. mos. ds.

(Signed) Leo V Eddy M. D.

Jany 30 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 10 days. In the State 30 yrs. ... mos. ... days.

Where was disease contracted if not at place of death? Dont Know

Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL: Pocatello | DATE OF BURIAL: Feby 1 1914

20. UNDERTAKER: Crawford & Eldredge | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham — Registration District No. 121
City of Thomas — Primary Registration District No. 2194
(No. ....., ... St.)
File No. 6929
Registered No. 10
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Murdock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Single

6. DATE OF BIRTH — Jan (Month) 31 (Day) 1916 (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 9 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bingham

10. NAME OF FATHER Leo D. Murdock

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Francis Dance

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L J Murdock
(Address) Thomas

15. Filed June 26th 1914 — M. E. Parkis, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH — Jan (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1914, to Jan 31 1914, that I last saw h[illegible] alive on Jan 31 1914, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Premature Birth
4 months.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L J Simmons M. D.
1/31 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Thomas Cemetery	Jan 31 1914

20. UNDERTAKER	ADDRESS
L J Woodruff	Blackfoot Route # 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. ~~21~~ 2194
File No. 6930
Registered No. 11

1. PLACE OF DEATH.
County of Bingham
City of R F D 2
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Angeline Gardner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. March (Month) 7 (Day) 1833 (Year)
7. AGE: 80 Yrs. 10 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: John Gould
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. E. Gardner
(Address) Blackfoot Route 2.
15. Filed Jan 23 1914 W. E. Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 23 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h— alive on ——— 191..., and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
General Debility
Complicated by Old Age
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration — yrs. — mos. — ds.
(Signed) J. B. Davis M. D.
1-23 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Brigham City Utah — DATE OF BURIAL: ..... 191...
20. UNDERTAKER: E J Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6931
Registered No. ____
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of St Anthony (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 3177

2. FULL NAME Elsie Woodfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 17 1895
(Month) (Day) (Year)

7. AGE: 18 yrs. 4 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Factory Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): Everett B. Clark Pea Co

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Woodfield

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Rose

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Woodfield
(Address) St Anthony

15.
Filed Feby 9 1914
Roswell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan 22 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1914, to Jan 22 1914, that I last saw her alive on Jan 22, 1914 and that death occurred on the date stated above, at 1:00 M.

The CAUSE OF DEATH* was as follows:

1st Pneumonia

(Duration) ____ yrs. ____ mos. 3 ds.

Contributory [redacted]
(Secondary)

(Duration) ____ yrs. ____ mos. [redacted] ds.

(Signed) J. P. Woodfield M. D.

Jan 22 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State ....yrs....mos....days.

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Milford Idaho
DATE OF BURIAL: Jan 22 1914

20. UNDERTAKER: None
ADDRESS: None

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6935
Registered No.

1. PLACE OF DEATH.
County of Franklin
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Loveland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Aug (Month) 7 (Day) 1911 (Year)

7. AGE: 2 yrs. 5 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harlon Loveland

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Amelia Walker

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): A P Mansfield
(Address): St Anthony Ida

15. Filed Feb 9 1914
W Beard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1914, to Jan 27 1914, that I last saw her alive on Jan 26 1914, and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A P Mansfield M. D.
Jan 27 1914 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parker Ida	Jan 28 1914
20. UNDERTAKER: None	ADDRESS: None

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6936

Registered No.

1. PLACE OF DEATH.
County of Fremont
City of Egin

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Everett Herbert Moore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 16 1895
(Month) (Day) (Year)

7. AGE: 18 yrs. 4 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Egin Idaho

10. NAME OF FATHER: Herbert Moore

11. BIRTHPLACE OF FATHER (State or Country): Farmington Utah

12. MAIDEN NAME OF MOTHER: Annie Harris

13. BIRTHPLACE OF MOTHER (State or Country): Malad City Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W Everett
(Address) St Anthony Ida

15. Filed Jan 9 1914 W Everett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 15 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1914, to Jan 15 1914
that I last saw him alive on Jan 15 1914
and that death occurred on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Everett M. D.
19..... (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker Ida
DATE OF BURIAL: Jan 15 1914

20. UNDERTAKER: None
ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 6936

Name Everett Heber Moon

Date of Death Jan. 15. 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) W. D. Wm X M.D. M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6937
Registered No.

1. PLACE OF DEATH.
Registration District No. 99
County of Fremont
Primary Registration District No. 2177
City of St Anthony (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lorra Eastman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 2 (Day) 1898 (Year)

7. AGE: 16 yrs. 11 mos. 28 ds.
IF LESS than 1 day how many ... hrs. or ... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: student
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holton Kan.

10. NAME OF FATHER: Fred Eastman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Boucher
(Address) St Anthony Ida

15.
Filed Feb 7 1914 W Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1914, to Jan 31 1914
that I last saw her alive on Jan 31 1914
and that death occurred on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:
Organic Heart Lesion

(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) Chlorhea
(Duration) ... yrs. 1 mos. 0 ds.

(Signed) J. E. Boucher M. D.
2/3 1914 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. 0 5 7
In the State dont Know yrs ... mos ... ds.
Where was disease contracted, if not at place of death? dont Know probably here.
Former or usual residence dont Know

19. PLACE OF BURIAL OR REMOVAL: Boise
DATE OF BURIAL: 2/3 1914

20. UNDERTAKER: W. D. Yager
ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No.
(No. , St.)

File No. 6938
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Clarence H. Nisson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Oct (Month) 8 (Day) 1913 (Year)

7. AGE: yrs. 3 mos. 12 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER: Chas Nisson

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Nillie Jordan

13. BIRTHPLACE OF MOTHER (State or Country): Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Nisson
(Address) Rupert.

15. Filed Jan 21 1914 — O. H. Scott, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1914, to Jan 20 1914
that I last saw h[illegible] alive on Jan 20 1914,
and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) 12 hrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. B. Kemagy M. D.
1/20 1914 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida — DATE OF BURIAL: Jan 21 1914

20. UNDERTAKER: W A Goodman — ADDRESS: Rupert

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6939

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Cassia

City of Jackson

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William T Johns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write Word): Married

6. DATE OF BIRTH. May (Month) 9 (Day) 1843 (Year)

7. AGE: 71 Yrs. 10 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: dont Know

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Johns
(Address) Jackson Idaho

15. Filed ..... 191.....

D H Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH was as follows:
No Physician called
Death sudden

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jackson — DATE OF BURIAL: June 28 1914

20. UNDERTAKER: W. A. Goodman — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24958

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6940

Registered No. 1

1. PLACE OF DEATH.

County of Lewis

City of Nobles

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. Stellen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: not known exactly

1 (Month) (Day) (Year)

7. AGE: 78 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos Stellen (son)

(Address) Nobles Idaho

15.

Filed 1-22 1914 W M Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 22 1914

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from had no 191, to 191, that I last saw h alive on doctor 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory Senility

(Secondary)

(Duration) yrs. mos. ds.

(Signed) C C Jayne M. D.

1-23 1914 (Address) Nobles Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Central Ridge

DATE OF BURIAL: 1-24 1914

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6941
Registered No. 2

1. PLACE OF DEATH.
County of Lemhi
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47
Primary Registration District No. 2124
(No. ....., ... St.)

2. FULL NAME Dorothy Elvira Faier

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH: 1 (Month) 14 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: #
(b) General nature of industry business, or dstablishment in which employed (or employer): #

9. BIRTHPLACE (State or Country): Nezperce Ida

10. NAME OF FATHER: Nicholas Faier

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Hazel Murry

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. A. Jeffreys
(Address) Nezperce Ida

15. Filed 1-15 1914 J. M. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-14 1914, to 1-17 1914, that I last saw h[illegible] alive on 1-16 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Mother relived baby was dead 10 or 15 minutes after running.
Cause of death was from ~~tuberculosis~~ (no autopsy allowed.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Previous health good
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. A. Jeffreys M. D.
19..... (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nezperce	1-18 1914

20. UNDERTAKER	ADDRESS
Miller	Nezperce

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. ~~2205~~ 122

Primary Registration District No. 2205

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 694

Registered No. 3

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Stolle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 43 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): .....

10. NAME OF FATHER: Fred Stolle

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lizzie E. Ward
(Address) Wallace Ida

15. Filed Jan 28 1914 W. A. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:
Electrocuted by
6000 volt current

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. A. Mowery M. D.

Jan 27 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ypsilanti Mich | DATE OF BURIAL ..... 191...

20. UNDERTAKER: Ward Undertaking Co | ADDRESS Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2208
File No. 6944
Registered No. 1

1. PLACE OF DEATH.
County of Shoshone
City of Avery Ida
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Wheatley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Dont Know (Month) 1850 (Year) (Day)

7. AGE: 65 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: James Wheatley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank J O'Hare
(Address) Avery

15. Filed Jan 17 1914 H C Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24th 1914, to Jan 13 1914, that I last saw him alive on Jan 13 1914 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Capillary Bronchitis

(Duration) ..... yrs. ..... mos. 20 ds.
Contributory (Secondary) Chronic Bronchitis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) L T Smith M. D.
Jan 13 1914, (Address) Avery Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte Mont — DATE OF BURIAL: Jan 16 1914

20. UNDERTAKER: Mulcahy — ADDRESS: St Maries Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2072
File No. 6946
Registered No. 3

1. PLACE OF DEATH.
County of Blaine
City of Stanton
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Lee

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	Indian.	married.

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE about 7.
49 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nevada

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Lee
(Address) Bellevue Idaho.

15.
Filed Jan 30 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan 28 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:
Gunshot wound
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory —
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
Jan 29 1914 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hailey Idaho | DATE OF BURIAL Jan 30 1914

20. UNDERTAKER W. D. Harris | ADDRESS Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 6947
Registered No. 2

1. PLACE OF DEATH.
County of Boise
City of Hailey, (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thos. James Reid.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	Wht.	Married

6. DATE OF BIRTH: May (Month) 5th (Day) 1854 (Year)

7. AGE: 59 yrs. 8 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Saloon Keeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brooklyn N. Y.

10. NAME OF FATHER: T. J. Reid

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos. E. Reid Jr.
(Address) Ketchum

15. Filed Jan 15 1914 Robert L. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 17th (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1913, to Jan 12 1914, that I last saw him alive on Jan 11 1914, and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Cerebral Embolism

(Duration) ..... yrs. 1 mos. 0 ds.
Contributory (Secondary) Pericarditis with a slight endocardial infection
(Duration) ..... yrs. 1 mos. 10 ds.

(Signed) John J. Rand M. D.
Jan. 19 1914 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ketchum	1-13-1914

20. UNDERTAKER	ADDRESS
Ralph D. Harris	Hailey Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 21
County of Blaine Primary Registration District No. 2022
City of Hailey (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Fred Reid —

File No. 6943
Registered No. 1
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: About 60 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo H Jacobs
(Address) Hailey Ida.

15. Filed Jan 2 1913 Robert H Livingston Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29th 1913, to Jan 1st 1914, that I last saw h— alive on Jan 1st 1914, and that death occurred on the date stated above, at 6:30 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Edema
.....
.....
..... (Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Alcoholism
..... (Duration) 10 yrs. ..... mos. ..... ds.
(Signed) Robert H Livingston M. D.
Jan 1st 1914 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida. DATE OF BURIAL: Jan 3rd 1914

20. UNDERTAKER: Nordquist ADDRESS: Hailey Ida.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 18672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9C

County of Nez Perce Primary Registration District No. 1009

City of Lewiston (No. Hospital, St.)

File No. 6943

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Forgey Clift

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 1 (Day) 1877 (Year)

7. AGE: 37 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Elias Forgey

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Cathrine Holman

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Clift
(Address) Asotin Wash

15. Filed Feb. 10 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jany (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1913, to Jany 1 1914 that I last saw h[illegible] alive on Jany 1 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Following Abdominal Operation

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Rupture Abdominal Cavity

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Woodruff M. D.

..... 19 ..... (Address) Asotin Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 day ..... yrs ..... mos ..... ds.
In the State St Joseph ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? Dont know
Former or usual residence Asotin Wash

19. PLACE OF BURIAL OR REMOVAL: Asotin Wash
DATE OF BURIAL: Jan 3 1913

20. UNDERTAKER: H P Merchant
ADDRESS: Asotin Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 695
Registered No. 2

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston Ida
Registration District No. 9L
Primary Registration District No. 1009
(No. Poor Farm St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C.A.H. Landon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1843 (Year)

7. AGE: 70 yrs. 3 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Ludwig Landon

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Kavan

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C.T. Strahahan
(Address) Lewiston Ida

15.
Filed Feb 10 1914 E.J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1913, to Jan 5 1914 that I last saw h~~im~~ alive on Jan 5 1914 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Paralysis = Hemiplegia

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Arteris-sclerosis
(Duration) Years yrs. ..... mos. ..... ds.

(Signed) C.T. Strahahan M. D.
1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Comty Hospital 1 yrs. 10 mos. — ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: Jan. 6 1914

20. UNDERTAKER: Hanson
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston (No. 2310 8th Ave St.)

File No. 6951

Registered No. B

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. Stillman Babcock

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Aug. 20 (Month) (Day) 1834 (Year)

7. AGE: 79 yrs. 4 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Cooper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Courtland Co. N. Y.

10. NAME OF FATHER: Reuben Babcock

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Louisa Palmer

13. BIRTHPLACE OF MOTHER (State or Country): N. Y. State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence B. Rice
(Address) Lewiston - Ida

15.
Filed Feb. 10 1914 L. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Arterio-sclerosis

(Duration) for several years yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. J. Perkins M. D.
1-6 19 14 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Jan 8 1914

20. UNDERTAKER: L. Casar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 6953
Registered No. 5

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. 411, Cedar St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Robinson Infant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Single

6. DATE OF BIRTH
1 (Month) 12 (Day) 1914 (Year)

7. AGE
— yrs. — mos. — ds.
IF LESS than 1 day how many ..1.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Lewiston

10. NAME OF FATHER John Robinson

11. BIRTHPLACE OF FATHER (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Edna Puckett

13. BIRTHPLACE OF MOTHER (State or Country) Colton Wn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C J Vassar
(Address) Lewiston

15.
Filed Feb 10 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1—12—1914, to ..... 191..., that I last saw him alive on 1—12 1914 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
(Premature birth.)

(Duration) one hour. yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. H. Harris M. D.
1-12-1914 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston | DATE OF BURIAL: 1-12 Jan 191..

20. UNDERTAKER: C J Vassar | ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

6-7 Jan 12,

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 1909
File No. 6951
Registered No. 6

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 718, New 6th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Westendahl

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: March (Month) 10 (Day) 1831 (Year)

7. AGE: 82 yrs. 10 mos. 6 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: J Berstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Jonsson
(Address) Lewiston

15.
Filed Feb. 10 — 1914 L. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30th 1913, to Jan. 9th 1914, that I last saw her alive on Jan. 9th 1914, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Jonsson M. D.
1/16 1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston I. | DATE OF BURIAL: 1/17 1914

20. UNDERTAKER: C. Jonsson | ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 97
Primary Registration District No. 97
(No. ..... St.)

File No. 6955
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin E. Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept. (Month) 18 (Day) 1878 (Year)

7. AGE: 35 yrs. 4 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Wm E. Campbell

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mary Sinclair

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse M. Campbell
(Address) Gifford Ida.

15. Filed Sept 1 1914 John Malley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1912, to Jan 1914, that I last saw h- alive on 3-15 1914 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

(Duration) 2 yrs. mos. ds.
Contributory Bronchitis
(Secondary)
(Duration) 6 yrs. 6 mos. ds.

(Signed) John N Malley M. D.
Sept 1 1914 (Address) Lapwai Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rubens — DATE OF BURIAL: 2-2 1914

20. UNDERTAKER: J A Wallace — ADDRESS: Lapwai Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 6956
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lola Bertha Savage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 12 (Day) 1866 (Year)

7. AGE: 48 yrs. 10 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boulder Co Utah.

10. NAME OF FATHER: George Graham

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Phoebe Allen

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. K. Savage
(Address) Burley Ida

15.
Filed 1-18- 1914
R. P. Storey Dep.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 13- (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13- 1914, to Jan 13- 1914
that I last saw her alive on December 1914
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy
a few minutes
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Truesdell M. D.
1-19 1914 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Jan. 17 1914

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 695

Registered No. 24

1. PLACE OF DEATH.
County of Lemhi
City of Salmon Hot Springs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

2. FULL NAME James Butler

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
Do not know exact date
(Month) (Day) (Year)

7. AGE
78 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Quartz Miner
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Durand.
(Address) Salmon Idaho.

15.
Filed January 16 1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January 16" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 14 1914, to Jan. 16" 1914, that I last saw h[illegible] alive on Jan. 14 1914, and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. D. Hutton M. D.
1/16 1914 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salmon Cemetery	Jan 16" 1914

20. UNDERTAKER	ADDRESS
J. C. Doebler	Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69

Primary Registration District No. 2128

File No. 6960

Registered No.

County of Lemhi

City of Kamiah (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vincent Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov 29th 1913 (Month) (Day) (Year)

7. AGE: yrs. 1 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Half of a child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kamiah

10. NAME OF FATHER: Mark Allen

11. BIRTHPLACE OF FATHER (State or Country): Gifford

12. MAIDEN NAME OF MOTHER: Edna Newman

13. BIRTHPLACE OF MOTHER (State or Country): Kamiah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edna Newman
(Address) Kamiah Idaho

15.
Filed 1-29 1914 E Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 - 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1914, to Jan 20 1914, that I last saw him alive on January 20 1913, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery.
Lagy

(Duration) yrs. mos. 10 ds.

Contributory (Secondary) Dysentery

(Duration) 0 yrs. mos. 5 ds.

(Signed) E Taylor M. D.

19 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Cemetery Nr 2

DATE OF BURIAL: Jan 22nd 1914

20. UNDERTAKER: E Johnson

ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6961
Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
Registration District No. 46
Primary Registration District No. 2126
(No. ..., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecelia G. Carter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 11th 1898 (Month) (Day) (Year)

7. AGE: 15 yrs. 10 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hat & a Child
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lawpai

10. NAME OF FATHER: Wm Carter

11. BIRTHPLACE OF FATHER (State or Country): Kamiah

12. MAIDEN NAME OF MOTHER: Julia Norman

13. BIRTHPLACE OF MOTHER (State or Country): Kamiah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia H Carter
(Address) Kamiah Idaho

15.
Filed 2-8 1914
E Taylor M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 2 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1913, to July 6 1913
that I last saw her alive on July 3 1913
and that death occurred on the date stated above, at 6:30 A M.
The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 4 yrs. 9 mos. 21 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) E Taylor M. D.
2-2 1913 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian (her own)
DATE OF BURIAL: Feb 3rd 1914
20. UNDERTAKER: C J Johnson
ADDRESS: Kamiah Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

County of Lincoln

Primary Registration District No. 2016

File No. 6965

City of Shoshone

(No. ....., ... St.)

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bona Reynolds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH ~~Jan 3 1914~~

Oct. (Month) 21 (Day) 1865 (Year)

7. AGE: 48 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Jacob Rafston

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Margret Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jake Rolfsen

(Address) Shoshone, Ida

15.

Filed Jan. 5 1914 C. F. Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 1914, to Jan. 3 1914, that I last saw h.. alive on Jan. 3 1914, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia following Influenza.

(Duration) ..... yrs. ..... mos. 16 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Nelson M. D.

19 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Pleasant Utah

DATE OF BURIAL: 1/6 1914

20. UNDERTAKER: O. J. Brennan

ADDRESS: Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 2016
(No. ....., ... St.)

File No. 6966
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Marriotte

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Divorced

6. DATE OF BIRTH: 7 Sept 1861
(Month) (Day) (Year)

7. AGE: 52 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter and Paper Hanger
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ills

10. NAME OF FATHER: John Marriotte

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Emely Hardick

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hollie Marriott
(Address) Shoshone, Idaho

15. Filed Feb. 4 1914 C. F. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 30 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1914, to Jan. 30 1914, that I last saw h[illegible] alive on Jan. 29 1914, and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Interstitial Nephritis

(Duration) 8 yrs. ..... mos. ..... ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) C. F. Zeller M. D.
19 ..... (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida
DATE OF BURIAL: 2/5 1914

20. UNDERTAKER: O. J. Brennan
ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 6973
Registered No. 1

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. 424, Everett St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mattie D. Stubbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
April (Month) 18th (Day) 1866 (Year)

7. AGE
47 yrs. 9 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER
Dr. F. K. Transue

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER
Martha A. Price

13. BIRTHPLACE OF MOTHER
(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. D. Mumford
(Address) Caldwell Idaho

15.
Filed January 19 1914 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1914, to Jan 17 1914, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Patient had been treated for nephritis by dr. Numbers Burnside Hyd Uremic Convulsion in Coldwell died before I could reach her home
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Cole M. D.
Jan. 19 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 1/19 1914

20. UNDERTAKER: W. G. Dyer
ADDRESS: Caldwell, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

File No. 697

Registered No. 2

County of Canyon

City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Mc Farland.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: May (Month) 20 (Day) 1837 (Year)

7. AGE: 76 yrs. 7 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Oliver Lindsay

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Georgia M. Farland
(Address) 811 Chicago St.

15. Filed Jan. 7th 1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/1/13 191.., to 1/6/14 191.., that I last saw her alive on 1/5/14 191.., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancerous
Thigh

(Duration) 1 yrs. 6 mos. ..... ds.

Contributory (Secondary) Lymphatic adenitis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) W. H. Fortner M. D.

1/7/14 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Jan 7 1914

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 6975
Registered No. 3

1. PLACE OF DEATH.
County of Canyon
City of Conely Farm (No. Caldwell-Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Truman

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (write the word.): Widower

6. DATE OF BIRTH: Sept. (Month) 12 (Day) 1824 (Year)

7. AGE: 89 yrs. 4 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Trapper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): ✓ ✓

12. MAIDEN NAME OF MOTHER: ✓ ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. E. Pearson
(Address) Caldwell

15.
Filed Jan. 12 1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1913, to Jan 10 1914 that I last saw h alive on Dec 28 1913 and that death occurred on the date stated above, at 7 30 P. M.

The CAUSE OF DEATH* was as follows:
Cystitis

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) T. M. Coe M. D.
Jan 12 1914 (Address) Caldwell, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: Jan 12 1914

20. UNDERTAKER: W C Dye
ADDRESS: Caldwell Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6975

Registered No. 4

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dora Schroane Beedle Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: October (Month) 18 (Day) 1857 (Year)

7. AGE: 56 yrs. 3 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Madison Co. Iowa.

10. NAME OF FATHER: John R. Beedle

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Isabelle Carson

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Cox

(Address) Middleton Idaho

15.

Filed Feb. 3 1914 Jos. D. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1914, to Feb 1 1914, that I last saw her alive on Feb 1 1914, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Acute Hepatitus

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Miller M. D.

2-1-1914 (Address) Coalmine Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Feb 3 1914

20. UNDERTAKER: W C Dyer — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Caldwell (No. ....., ... St.)
File No. 6977
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth M Noble.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 43 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Thomas K Monroe

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Jamaison
(Address) Caldwell

15. Filed Feb. 7 1914 John D. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 5 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1914, to ..... 191..
that I last saw h.. alive on 2-5 1914
and that death occurred on the date stated above, at 1-30 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary embolism

..... (Duration) 15 minutes yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
2/7 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Grafton N. Dak. DATE OF BURIAL ..... 191..

20. UNDERTAKER: Peckham Co ADDRESS: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 6975
Registered No. 6

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mathew Proud

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1849 (Year)

7. AGE: 65 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Proud

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Kirkpatric

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse L Proud
(Address) Homedale

15.
Filed Feb. 6 1914 John D. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-3-14 191.., to 2-5 1914, that I last saw him alive on 2-5 191.., and that death occurred on the date stated above, at 1.00 A.M.

The CAUSE OF DEATH* was as follows:

Suppression of urine and hypostatic pneumonia suppression caused by being exposed to severe cold 18 hrs and had both legs & hands frozen

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Exposure to severe cold 2 days

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M Reed M. D.

2/6 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 2/6 1914

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 6989
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian (No. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ellen Lyrone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widow
6. DATE OF BIRTH: Jan (Month) 14 (Day) 1842 (Year)
7. AGE: 72 yrs. = mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Penn
10. NAME OF FATHER: John Pirtle
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Ella Pirtle Do not Know about name of mother
13. BIRTHPLACE OF MOTHER (State or Country): Penn.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm Lyrone
(Address): Kuna Idaho
15.
Filed Jan 22 1914 C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1914, to Jan 20 1914
that I last saw h-r alive on Jan 18 1914,
and that death occurred on the date stated above, at 5- P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) yrs. mos. 6 ds.
Contributory (Secondary) General Debility
(Duration) yrs. mos. ds.
(Signed) J. F. Pryce M. D.
Jan 21 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Boise Idaho. DATE OF BURIAL: 1-22 1914
20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 11

Primary Registration District No. 2025

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6981

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence A Riedell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 12 (Day) 1884 (Year)

7. AGE: 30 Yrs. 10 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Echo Minn.

10. NAME OF FATHER Wm F Riedell

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Sophia Bokoman.

13. BIRTHPLACE OF MOTHER (State or Country) Berlin Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Oscar F Riedell.
(Address) Meridian RD 2

15. Filed Jan 20th 1914 — C L Sutton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1911 1914, to Jan 20 14 — 191..., that I last saw him alive on Jan 18 — 1914, and that death occured on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis (Interstitial)
Complicated with General
Anasarca - Fatal Attack
Uræmia & Acute Nephritis
(Duration) 2 yrs. 7 mos. ds.
Contributory
(Secondary)
(Duration 7 yrs. 7 mos. ds.
(Signed) C L Sutton M. D.
1-20 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Jan 21 1914

20. UNDERTAKER: W D Shelbourn — ADDRESS: Nampa.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BORS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6982
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of near Ustick
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. near, Ustick Station St.)

2. FULL NAME Jennie Wilhite

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Aug (Month) 24 (Day) 1884 (Year)

7. AGE
29 yrs. 3 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER W. H. Kidwell

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER M. J. Compton

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Kidwell
(Address) Council Ida.

15. Filed Feb 6th 1914 C. L. Dalton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Nephritis
in Postmortem statement
Assistant Surgeon
Over (Duration) 2 yrs. 2 mos. 1 ds.

Contributory (Secondary)
(Duration) Ete yrs. 16 mos. — ds.
(Signed) C. L. Dalton — M. D.
Feb 6 1914 (Address) Meridian Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 2/6 1914

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada.
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2003.
(No. ....., ... St.)

File No. 6983
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Geo. C. Gregory.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 20 (Day) 1835 (Year)

7. AGE: 78 yrs. 3 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Johonathan Gregory

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Sarah Ellis

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Brooks
(Address): Meridian Idaho

15. Filed Feb-4th 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr. (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1914., to Febr. 2 1914
that I last saw him alive on Feb. 1 1914.,
and that death occurred on the date stated above, at 6.45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) La Grippe

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Neal M. D.

Feb 3 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cem. DATE OF BURIAL: Feb-4 1914

20. UNDERTAKER: None ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6985

Registered No. 2

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168

2. FULL NAME John Lambert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1840 (Year)

7. AGE
74 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ills

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Blair E. Moon
(Address) Orofino, Ida

15.
Filed Jany 20 1914 J. M. Darby
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jany (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191...
that I last saw h... alive on ~ 191...
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Unknown
Found dead in his Cabin
several days after death

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Darby M. D.
Jany 19 1914 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Orofino, Ida — DATE OF BURIAL Jany 18 1914

20. UNDERTAKER W. E. Hoddard — ADDRESS Tufford Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

...YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Grafino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 698
Registered No. 1

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White Indian
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) 31 (Day) 1913 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Paul C. Morris

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Parton

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul C. Morris
(Address) Grafino, Ida

15. Filed Jany 2 1914 J. M. Towle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 2 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1913, to Jany 2 1914 that I last saw him alive on Jany 1 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Towle M. D.
Jany 2 1914 (Address) Grafino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grafino Ida — DATE OF BURIAL: Jany 2 1914

20. UNDERTAKER: W. E. Haddock — ADDRESS: Grafford, Ida

GEM-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6987
Registered No. 1

1. PLACE OF DEATH.
County of Canyon
City of 5 mi-N-E Falk-
(No. ....., ... St.)
Registration District No. 4
Primary Registration District No. 1008.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Eldred Jesse Bohlcke.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M-	W.	Infant.

6. DATE OF BIRTH
Nov (Month) 8 (Day) 1913 (Year)

7. AGE
..... yrs. 2 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work ..... Infant
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oregon-

10. NAME OF FATHER Robert A. Bohlcke.

11. BIRTHPLACE OF FATHER (State or Country) Missouri-

12. MAIDEN NAME OF MOTHER Ruth Bowen.

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin-

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt A. Bohlcke-
(Address) Falk- Ida-

15.
Filed Jan 20 1914 J.C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~1913~~ viewed the remains, after death Jan 14 1914
that I last saw h..... alive on ..... 191....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
fracture of skull from accidental fall-

..... (Duration) ..... yrs. ..... mos. ½ hours.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm T Brydall M. D.
Jan 14 1914 (Address) Wm Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Falk, Idaho-
DATE OF BURIAL: Jan 15 1915

20. UNDERTAKER: C L Buckmun
ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6988

Registered No.

1. PLACE OF DEATH.

County of Canyon

City of (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ellen Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Apr (Month) 8 (Day) 1833 (Year)

7. AGE: 80 yrs. 9 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Samuel Buck

11. BIRTHPLACE OF FATHER (State or Country): South Carolina

12. MAIDEN NAME OF MOTHER: Margaret McDill

13. BIRTHPLACE OF MOTHER (State or Country): South Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H Brown
(Address) Nampa Ida

15.
Filed Feb 10 1914 S D Calanyr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 10 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1914, to Feb 10 1914
that I last saw her alive on Feb 10 1914,
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis Gallstones
Pneumonia
(Duration) ... yrs. ... mos. 5 ds.
Contributory (Secondary) Old age
(Duration) ... yrs. ... mos. ... ds.

(Signed) S D Calanyr M. D.
Feb 10 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Camden Ohio
DATE OF BURIAL ... 191...

20. UNDERTAKER: F. K. Robinson
ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 18672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of near Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 6980
Registered No.

2. FULL NAME Gotlieb Rathlisberger

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): widower

6. DATE OF BIRTH: ? (Month) (Day) 1 (Year)

7. AGE: 90 yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Braden
(Address) Nampa, Ida

15.
Filed Feb 10 1914 S A Calaway Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1914, to 1914, that I last saw him alive on Feb 6 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
senile gangrene

(Duration) yrs. 7 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. H. Ross M. D.
Feb 10 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rohrerlawn Nampa | DATE OF BURIAL: Feb 11 1914

20. UNDERTAKER: J B Shellabarger | ADDRESS: Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 699

Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Near Nampa (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

2. FULL NAME Oscar Hammer
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 34 yrs. - mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Aug Hammer

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Anna Brita

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gustaf Hammar
(Address) Old Idaho

15. Filed Jan 25 1914 S.D. Calaway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at 4 oSA M.
The CAUSE OF DEATH* was as follows:

Run over by R.R. Train
(Suicide)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F.C. Robinson M. D.
19..... (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 1/27 1914

20. UNDERTAKER: F.C. Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6991
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Ada Primary Registration District No.
City of — (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loyd Samuel Brockus

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sing G

6. DATE OF BIRTH: July (Month) 29 (Day) 1913 (Year)

7. AGE: — yrs. 5 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profesSsion, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Col. Russel Brockus

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Stella Brower

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Russell Brockus
(Address) Nampa, Ida, R.F.D

15. Filed 1-14 1914 P.D. Calanger Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191...
that I last saw h... alive on ✓ 191...,
and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH* was as follows:
Child was dead when parents awoke on morning of Jan 14th History & case gives no light (Duration) to ✓ yrs. ✓ mos. ✓ ds.
Contributory (Secondary) apparently in bed & well when put to bed.
(Duration) yrs. mos. ds.

(Signed) P.D. Calanger M. D.
1-14 1914 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Valley Cem. DATE OF BURIAL: 1-15 1914

20. UNDERTAKER: F. K. Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6992

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Owyhee
City of Reynal
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 7

2. FULL NAME Infant Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Dec 18 (Month) (Day) 1913 (Year)

7. AGE: ..... yrs. ..... mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wilson Ida (P.O.)

10. NAME OF FATHER: Chas. A Johnston

11. BIRTHPLACE OF FATHER (State or Country): Reynolds Ida

12. MAIDEN NAME OF MOTHER: Mary Kelly

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W H Arnold
(Address) Wilson Idaho

15. Filed Jan 2 1914 S D Calanger Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 2 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 1913 Dec 18 1913 that I last saw him alive on Dec 18 1913, and that death occurred on the date stated above, at 8 PM. 1-2-14

The CAUSE OF DEATH* was as follows:
Informant states that child died after brief illness with convulsions
(Duration) ..... yrs. 2 hrs. mos. 1 hour ds.
Contributory (Secondary) Probably due to imperfect digestion. Junket for child
(Duration) ..... yrs. ..... mos. ..... ds.
Cleft palate & hare-lip and
(Signed) Mrs. Nicholls present M. D.
(Address) S D Calanger MD Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilson Ida Cem — DATE OF BURIAL: 1-4-1914

20. UNDERTAKER: S B Shellabarger — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Sign as Health Officer

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wardner
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 173
Primary Registration District No. 2701
(No. ..... St.)

File No. 6994
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Sterling Griddell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: October (Month) 31 (Day), 1905 (Year)

7. AGE: 8 yrs. 2 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolboy
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Jno. Griddell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Minnie Wren

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Griddell
(Address)

15. Filed Jan 19 1914 Geo. D. Lesher. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Sarcoma of Hip.
Treated by different Doctors
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Mason, House Officer, M. D.
Jan 4 1914 (Address) Kellogg,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL [illegible]: Greenwood — DATE OF BURIAL: Jan 20 1914

20. UNDERTAKER: E. B. Chamberlain — ADDRESS: Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5995

Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Wardner
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 220 4
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Maggy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: Do not Know (Month) (Day) 1 (Year)

7. AGE: 51 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Edw. Coomb

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Do not Know.

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Ozelle Maggy Wardner

15.

Filed Feb 1st 1914 Geo. L. Leahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 30 1914, to Jany 31 1914, that I last saw h er alive on 1/31 1914, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Inspection of bowels.

(Duration) ..... yrs. \ mos. 11 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Mason M. D.

1/31 1914 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Calumet Michigan

DATE OF BURIAL: Feb 1 1914 (Expenses)

20. UNDERTAKER: H. H. Bulcahy

ADDRESS: Wardner

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2004

File No. 6996

Registered No. 6

1. PLACE OF DEATH.

County of Ada

City of near Boise (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Simeon A. Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Not Obtainable. (Month) 1 (Day) 1844 (Year)

7. AGE: 70 yrs. — mos. — ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Burnett
(Address) Soldiers' Home

15.
Filed 2 — 2 1914 McParker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913 to Jan 31 1914 that I last saw h in alive on Jan 30 1914 and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. — ds.

Contributory (Secondary): Senility

(Duration) yrs. mos. ds.

(Signed) Fred A Tillery M. D.

2/2 1914 (Address) Lack Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 2 1914

20. UNDERTAKER: Terry & Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida
City of Malad
(No. ....., ... St.)

Registration District No. 76
Primary Registration District No. 7069

File No. 6997
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William A. Richards

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 26 (Day) 1913 (Year)

7. AGE: ....Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Malad Idaho

10. NAME OF FATHER Fred J. Richards

11. BIRTHPLACE OF FATHER (State or Country) Malad Idaho

12. MAIDEN NAME OF MOTHER Sarah J. Adams

13. BIRTHPLACE OF MOTHER (State or Country) Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred J Richards
(Address) Malad Idaho

15. Filed January 9th 1914 — J. C. Ray, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1914, to Jan 27 1914, that I last saw h.....alive on .....191..., and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J F Allen M. D.

1/14 1914 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Jan 29 1914

20. UNDERTAKER: D. S. Johnson — ADDRESS: Malad Idaho

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name William A. Richards

Date of Death Jan. 27, 1914

Cause of Death Broncho Pneumonia

Contributary Cause of death

(Sign here) J F Clutton M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 6990
Registered No.

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Clay Cannon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1856 (Year)

7. AGE: 58 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.? —

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Delaware

10. NAME OF FATHER: Henry Cannon

11. BIRTHPLACE OF FATHER (State or Country): Delaware

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J C Osgood Jr
(Address) 8 mi. S.E. of Jerome

15. Filed Feb 4 1914
E. D. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1914, to Feb 2 1914, that I last saw him alive on Feb 2 1914, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Diabetes
Chronic (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Diabetic Coma
(Duration ..... yrs. ..... mos. 3 ds.

(Signed) E. D. Piper M. D.
Feb 4 1914 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary — DATE OF BURIAL: Feb 5 1914

20. UNDERTAKER: Ernest Witt — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29.
Primary Registration District No. 1050

File No. 700
Registered No. 19.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clyde Groves

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: July (Month) 11 (Day) 1895 (Year)

7. AGE: 18 yrs. 6 mos. 9 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolboy
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D. W. Groves

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Jennie Ayotte

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jennie Groves
(Address) .....

15. Filed 1-20 1914 Mrs. S. Leland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1. 1914 to Jan. 20 1914
that I last saw h im alive on Jan. 15 1914
and that death occurred on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:
Chronic diffuse nephritis.

.....(Duration).....yrs.....mos.....ds.

Contributory
(Secondary)
.....(Duration).....yrs.....mos.....ds.

(Signed) John O'Neil M. D.
Jan. 20 1914 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	Jan 21 1914
20. UNDERTAKER	ADDRESS
Cassedy & Nelson	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-1[illegible]12

CERTIFICATE O[illegible]H

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. [illegible]1

Primary Registration District No. 1

File No. 7091

County of Kootenai

City of Coeur D'Alene (No. ....., ... St.)

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Ritter

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widowed

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1837 (Year)

7. AGE: 77 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Anderson

(Address) 815 St Manns St

15.

Filed 1-20 1914 Marie Sabard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1914, to Jan 17 1914, that I last saw h[illegible] alive on Jan 17 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Not Known yrs. mos. ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Jan 20 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: Jan 21 1914

20. UNDERTAKER: [illegible] — ADDRESS: C d A

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29.
Primary Registration District No. 1030
File No. 1003
Registered No. 2

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha J. Oberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 3 (Day) 884 (Year)

7. AGE: 29 yrs. 3 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: Mitchell Koutch

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Oberg
(Address)

15. Filed Jan 14 1914 Mark Bland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9th 1914, to Jan 11th 1914, that I last saw her alive on Jan 11th 1914, and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Busby M. D.
Jan 1914 (Address) Coeur d'alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Com. DATE OF BURIAL: Jan 13 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19.
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 1703
Registered No. 23
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Nelson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apr. (Month) 28 (Day) 1872 (Year)

7. AGE: 42 yrs. 8 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: C. M. Frame

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. W. Nelson
(Address) Council

15.
Filed 1-13 1914 Mrs. E. W. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1912, to Jan. 13 1914, that I last saw h[er] alive on Jan 10 1914, and that death occurred on the date stated above, at 5a. M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Boyer M. D.
Jan. 15 1914 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: Jan 15 1914

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of C'd A

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29.

Primary Registration District No. 1050

(No. ....., ... St.)

File No. 7011

Registered No. 24

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Shin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	Single

6. DATE OF BIRTH

..... (Month) ..... (Day) 1864 (Year)

7. AGE

50 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER -

11. BIRTHPLACE OF FATHER (State or Country) -

12. MAIDEN NAME OF MOTHER -

13. BIRTHPLACE OF MOTHER (State or Country) -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J E Hazlett

(Address) Coeur d Alene

15.

Filed 1-17 1914 Max C Sorensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January (Month) 17th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1914, to Jan 17 1914, that I last saw h[illegible] alive on Jan 14th 1914 and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Injury by dog

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno D Bunday M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Forest Cem

DATE OF BURIAL [illegible] 1914

20. UNDERTAKER [illegible]

ADDRESS C'd A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20

County of Kootenai

Primary Registration District No. 1050

File No. 7005

City of Cda

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J Nelson Stranburn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1880 (Year)

7. AGE

64 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER J W Stranburn

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed 1-15 1914 Max C Adams
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jany (Month) 15th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1913, to Jan 14th 1914, that I last saw h.m alive on Jan 14th 1914 and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Myaemia

..... (Duration) ..... yrs. 6 or 8 wks. ..... ds.

Contributory Endocarditis
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis H. Most M.D.

Jan 15 1914 (Address) Coeur d' Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Lawn	Jan 17 1914

20. UNDERTAKER	ADDRESS
S J Lunn	Cda

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29,

Primary Registration District No. 1050

File No. 1

Registered No. 123

County of Kootenai

City of E. W. A.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Healm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widow

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1860 (Year)

7. AGE: 54 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: James McDonald

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Cathern McCahn

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Healy

(Address) Spragues Wash

15. Filed 1-19 1914 Max [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 19 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 26 1913, to Jan. 19 1914, that I last saw h[illegible] alive on Jan. 18 1914 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Dwyer M. D.

Jan 19 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spragues Wash | DATE OF BURIAL ..... 191...

20. UNDERTAKER: [illegible] | ADDRESS E W A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

File No. 7007

Registered No. 30

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Rischar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	W	widow

6. DATE OF BIRTH

1810
(Month) (Day) (Year)

7. AGE

64 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno Sur

(Address) 764 Sherman

15.

Filed 1-24 1914 Max A. Ballard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) 23rd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1913, to Jan 1914, that I last saw her alive on Jan 22 1914, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 1 yrs — mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Beeby M. D.

19 (Address) Coeur D'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Thomas	Jan 26 1914
20. UNDERTAKER	ADDRESS
J Sur	C.D.A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7008 1
Registered No. 3 1

PLACE OF DEATH.

County of Ruderais
City of Rose Lake
Registration District No. 29
Primary Registration District No. 1 & 3
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nick Nickerson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Dont Know, Supposed Single

6. DATE OF BIRTH: Believed to be January (Month) 17 (Day) 1914 (Year)

7. AGE: Dont Know — 56 to 58 yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): Cutting Wood for Ranchers

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Williams M.D.
(Address) Rose Lake Ida.

15.
Filed 1-16 1914
Dr. MAX A. DORLAND
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Believed to be January (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sunday January 18 1914, to ..... 191..
that I last saw him alive on Sunday January 18 1914 and that he is believed to have died on the date stated above, at ..... M.
The CAUSE OF DEATH* was believed to be as follows: from Premature Senility with Uraemia, and Auto-Intoxication

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Williams M. D.
January 20 1914 (Address) Rose Lake Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Same Place
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: 3 Miles North Rose Lake — DATE OF BURIAL: January 20 1914

20. UNDERTAKER: Harrison Bldg — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V

The deceased whose certificate of death is attached hereto, was found dead, one mile south of Rose Lake Ida., by Arthur Smelcher. Where found the deceased had been cutting wood. Tom Bowers was the last person to see deceased alive; This was Friday afternoon Jan'y 16th. and body was found on Sunday Afternoon the 18th. I reached the body about 4.30 P.M after the finding of the body and after several other parties had first seen it.

I have known decesed since Dec. 1910; There has been a progressing premature senility, an appearant mal-neutrition, with occasional attacks of billious indigestion. So far as I know he never complained of any heart disease .

I reported this case first to the Coroner immediately after returning from where we found the body, and again to day have made a type written report to him, covering all the facts in the case, so far as I knew ~~or to~~ verdict judge.

C E Washington M D

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of C d A
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29.
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 7001
Registered No. 32.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W Schnurr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	married

6. DATE OF BIRTH
..... (Month) ..... (Day) 187? (Year)

7. AGE
43 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Portland Or

10. NAME OF FATHER
John Schnurr

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER
—

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J W Schnurr
(Address) City

15.
Filed 1-30 1914 M. L. Borland
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Suicide from unknown
poison.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John Kaus Schnurr M. D.
19.. (Address) Coeur d'Alene.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Malad

Registration District No. 76
Primary Registration District No. 7069
(No. ....., ... St.)

File No. 7015
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Shaner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1 (Month) 28 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many .. 2 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Malad Ida.

10. NAME OF FATHER: John Shaner

11. BIRTHPLACE OF FATHER (State or Country): Pittsburgh. Pa.

12. MAIDEN NAME OF MOTHER: Millie Goddard.

13. BIRTHPLACE OF MOTHER (State or Country): Malad. Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Evans
(Address) Malad Ida.

15. Filed 1-29 1914 L. C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/28 1914, to 1/28 1914
that I last saw her alive on 1/28 1914
and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Premature.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Evans M. D.
1/29 1914 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad
DATE OF BURIAL: 1-29 1914

20. UNDERTAKER: None
ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ineda
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 7011
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME No Name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	Wh	

6. DATE OF BIRTH: 1 (Month) 29 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* 12 *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Isaac Wilson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Annie Mustead

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isaac Wilson
(Address) Malad City Idaho

15.
Filed 1-30 191 4 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-24-14 1914 to 1-29 1914, that I last saw her alive on 1-29 1914, and that death occurred on the date stated above, at 11 15 M.

The CAUSE OF DEATH* was as follows:
Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
1-30 1914 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad	1-30 1914
20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 1013

Registered No.

County of Ada

City of Boise (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward N. Burrows

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White	Single

6. DATE OF BIRTH

Dec 18 (Month) 1844 (Day) (Year)

7. AGE

69 yrs. 1 mos. 22 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Veteran Civil War.

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Hiram Burrows.

11. BIRTHPLACE OF FATHER (State or Country) Not obtainable

12. MAIDEN NAME OF MOTHER Sarah A. Burrows.

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Burnett

(Address) Soldiers' Home

15.

Filed 1 — 9 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1906 to Jan 9 1914, that I last saw h[illegible] alive on Jan 7 1914 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. mos. ds.

Contributory Myocarditis

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Partington M. D.

1/9 1914 (Address) Idaho Blds

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	Jan 11 1914

20. UNDERTAKER	ADDRESS
Frye & Summers	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Ada

Primary Registration District No. 2004

City of Near Boise

(No. Birch Near Boise St.)

File No. 3701

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Hawks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Jan 5 1914
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day how many ... hrs. or ... mins.? 7

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Moso Hawks

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Agnus McGrunty

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Moso Hawks

(Address) Boise

15.

Filed 1-6 191[illegible] M. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 6 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5th 1914, to Jan. 6 1914, that I last saw h[illegible] alive on Jan 6 1914, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Debility + Insufficient Development Premature birth

6 hrs.
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Allen Cashmeyer M. D.

1-6-1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ...

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetary — DATE OF BURIAL: Jan. 6 1914

20. UNDERTAKER: Ivy Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING — PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2004

File No. 701

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise (No. Thurman Ada Co St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Frank Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Married

6. DATE OF BIRTH: July (Month) 25 (Day) 1859 (Year)

7. AGE: 54 yrs. 5 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John Smith

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: May Sayer

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O B Hayden
(Address) Eagle

15. Filed 1 – 5 1914 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 3rd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1914, to Jan 3rd 1914, that I last saw him alive on Jan 3rd 1914, and that death occurred on the date stated above, at five minutes of five A.M.

The CAUSE OF DEATH* was as follows:

Edema of Lungs - Terminal Nefrion of Chronic Valvular Heart Disease

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Had pneumonia about a year ago

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. M. Taylor M. D.

Jan 4 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Jan 5 1914

20. UNDERTAKER: Idaho Undertaking Co ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. near Soldiers Home St.)

File No. 5

Registered No. 701

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Elizabeth Crouch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May 17th 1873 (Month) (Day) (Year)

7. AGE: 40 yrs. 7 mos. 27 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fremont Co Colo.

10. NAME OF FATHER: Richard Crouch

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Nancy Goodwin

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Helms
(Address)

15.
Filed 1-15 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 14th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2nd 1914, to Jan 14 1914, that I last saw her alive on Jan 12 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia
La Grippe

(Duration) ~~10~~ yrs. mos. 12 ds.

Contributory (Secondary) Myocarditis

(Duration) 42 yrs. mos. ds.

(Signed) R E S Lamb M. D.

Jan 15 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence near Wylia Station

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery | DATE OF BURIAL: 1/15 1914

20. UNDERTAKER: Schreiber & Siedenfaden | ADDRESS: Boise Idaho

SYMS - YORK CO., PTRS. & RDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2014

File No. 7016

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH

County of Ada

City of Boise (No. Beyond Meridian St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John McAllister

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Oct (Month) 27 (Day) 1844 (Year)

7. AGE: 69 yrs. 2 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): [illegible]

9. BIRTHPLACE (State or Country): Penna E[illegible]

10. NAME OF FATHER: Arch Mcallister

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mara A Hiatt

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J B Pattra

(Address) Eagle Idaho

15.

Filed 1-12 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) — 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1914, to Jan 10 1914, that I last saw h[illegible] alive on Jan 9 1914, and that death occurred on the date stated above, at 4[illegible] M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar

(Duration) ..... yrs. ..... mos. 6 days.

Contributory (Secondary) 0

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. C B Beller M. D.

1-11 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan 12 1914

20. UNDERTAKER: Jay [illegible] — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & RDRS. 19760



SUPPLEMENARY DEATH CERTIFICATE

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7016

Name John McAllister

Date of Death Jan. 10. 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) O.B. Beller M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 26

Registered No. 101

County of Ada

City of Boise

(No. 1418 East Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Lora B. Tuttle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 25th (Day) 1871 (Year)

7. AGE: 42 yrs. 3 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: G. W. Enfield

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Adeline Higgenbotham

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Enfield
(Address) Nampa Ida

15. Filed 1 — 26 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 7th 1914, to Jany 27 1914, that I last saw her alive on Jany 27 191..., and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) 4 yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W F Kinney M. D.

Jany 27 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence Nampa Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan. 29 1914

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. ....., ... St.)

File No. 25401

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Homer Agee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (or the word)

6. DATE OF BIRTH: Sep 28 (Month) (Day) 1877 (Year)

7. AGE: 37 yrs. 4 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Charles Agee

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Martha Poplin

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Abbie Agee
(Address) Buhl Idaho

15. Filed 1-27 1913 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 26 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1913, to Jan 26 1914, that I last saw h. alive on Jan 26 1914, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Appendicitis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Peritonitis
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jos Spriggs M. D.
Jan 27 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill	Jan 28 1914

20. UNDERTAKER	ADDRESS
Ivy & Summers	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24 [illegible]

PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1319 N 15 St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George William Holstead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
M	W	Married

6. DATE OF BIRTH: Mar (Month) 6 (Day) 1841 (Year)

7. AGE: 72 yrs. 10 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Henry W Holstead

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mahala Warren

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R J Bills
(Address) 1311 - 15

15.
Filed 1 - 28 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 26, (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1913, to Jan 27 1914
that I last saw h— alive on 27 Jan 1914
and that death occurred on the date stated above, at 7.30 M.

The CAUSE OF DEATH* was as follows:
Cardiac Stenosis

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. C. Church M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill | DATE OF BURIAL: Jan 28 1914

20. UNDERTAKER: Terry & Summers | ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2340

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 5 Fifteenth Ward St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph Lindeman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH Not Obtainable 1855
(Month) (Day) (Year)

7. AGE 64 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Miner
(b) General nature of industry business, or dstablishment in which employed (or employer) ....

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. O. Miller

(Address) Boise Ida

15.

Filed 1-26 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH January 26 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1914, to Jan 26 1914, that I last saw he alive on Jan 25 1914 and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ....

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. E. Springer M. D.

Jan 26 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Morris Hill Cemetery Jan 28 1914

20. UNDERTAKER | ADDRESS

Troy Cummings Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 22 7021

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 812, Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dora Bell Eby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: October (Month) 31 (Day) 1861 (Year)

7. AGE: 52 yrs. 2 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oscaloosa Iowa

10. NAME OF FATHER: Adam Eichelberger

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Cynthia Graham

13. BIRTHPLACE OF MOTHER (State or Country): Hendricks Co. Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert V. Eichelberger
(Address) 715 N. 9th St Boise

15.
Filed 1-26 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9th 1913, to Jan 25 1914, that I last saw h.er alive on Jan 23 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C W Kingsbury M. D.

1914 (Address) Idaho Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan. 27 1914

20. UNDERTAKER: Schreiber & Liedtfeldt | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 21 7022

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 112, E. Bannock St.)

2. FULL NAME William Carmen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1867 (Year)

7. AGE: 46 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: H. H. Carmen

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Lucinda Scroll

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lucinda Fields
(Address) .....

15.
Filed 1-23 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 23rd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25th 1914, to Jan 23 1914, that I last saw h— alive on Jan 22 1914, and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease & Brights disease

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E Stuck M. D.

19.... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Co — DATE OF BURIAL: Jan 24 1914

20. UNDERTAKER: Pierce & Hickman Plat — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 20 7023

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH.

County of Boise

City of Ada

(No. 1916, 11 & 7th St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Shirley Faunta Good

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	Single

6. DATE OF BIRTH: 26 October 1913 (Month) (Day) (Year)

7. AGE: yrs. Two mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada County

10. NAME OF FATHER: John R. Good

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Helen Bryan

13. BIRTHPLACE OF MOTHER (State or Country): Boise Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs J. R. Good

(Address): Mora Ida

15. Filed 1-23 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 23 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1914, to Jan 23 1914, that I last saw her alive on Jan 22 1914, and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Cryptogenetic septicemia
(Primary, Secondary or Unknown)
Origin

(Duration) yrs. mos. 8 ds.

Contributory (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) T. N. Braxton M. D.

Jan 23 1914 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 24 1914

20. UNDERTAKER: Cloverleaf Undertaking Co | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 112 E. Bannock St.)

File No. 19 702
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 1st (Day) 1905 (Year)

7. AGE: 9 yrs. 0 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bellevue Idaho.

10. NAME OF FATHER: Walter T. Wright

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Sarah E. Carpenter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter T. Wright
(Address) Bellevue Idaho

15.
Filed January 23rd, 1914 W. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jany (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/17 191.., to 1/23 1914
that I last saw h.. alive on 1/23 1914
and that death occurred on the date stated above, at ..M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Lipic Ventricular
(Duration) ..yrs. ..mos. 8 ds.
Contributory
(Secondary)
(Duration) ..yrs. ..mos. ..ds.

(Signed) James L. Almost M. D.
1/23 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs. ..mos. ..days. In the State ..yrs. ..mos. ..days.
Where was disease contracted if not at place of death?
Former or usual residence: Bellevue, Idaho

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Idaho
DATE OF BURIAL: Jan. 24 1914

20. UNDERTAKER: Schreiber & Sidwell
ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 415 Washington St.)

File No. 16 702
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan 16 1914 (Month) (Day) (Year)

7. AGE: Still Born yrs. mos. ds.
IF LESS than 1 day how many hrs. or 10 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Chas Stewart

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Lillian Bakalen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles L Stewart
(Address) Boise

15.
Filed 1-17 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 16 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ...191..., to ...191..., that I last saw h...alive on...191..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:
Still born

(Duration) ...yrs. ...mos. ...ds.

Contributory (Secondary)
(Duration) ...yrs. ...mos. ...ds.

(Signed) Chas Callett M. D.
19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery
DATE OF BURIAL: 1/17 1914

20. UNDERTAKER: Schreiber & Siebenfaden
ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 517 Martha 10½ St.)

File No. 15025

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Morton Berthold

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: September 21 (Month) (Day) 1857 (Year)

7. AGE: 56 yrs. 3 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mngr Electricity Co
(b) General nature of industry business, or dstablishment in which employed (or employer): Electrical

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Wm Henry Berthold

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Maria Catherine Braun

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Silas M. Levick
(Address): Boise Idaho

15.
Filed 1 — 16 1914 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 15 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to Jan 1914, that I last saw her alive on Jan 13 1914, and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hours (Duration) 8 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

1/15 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan [illegible] 1914

20. UNDERTAKER: Schreiber & Kiesenstein — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 918, Idaho St.)

File No. 13 702

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vicente Ignacio Aguirre

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 20 (Day) 1912 (Year)

7. AGE: 1 yrs. 7 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: Francisco M. Aguirre

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Cegabina Cegontia

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francisco M. Aguirre
(Address) 918 Idaho

15.
Filed 1-14 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 14th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1914, to Jan 14 1914
that I last saw h..... alive on Jan 14 1914
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence 918 Idaho St.

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 1/16 1914

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 12 702

County of Ada

City of Boise

(No. 112, E. Bannock St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. L. H. Helen Waters

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 13 (Day) 1858 (Year)

7. AGE: 55 yrs. 8 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): not obtainable

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Waters

(Address) Pinehurst, Idaho,

15.

Filed 1-14 1914 W. A. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

DATE OF DEATH: Jan (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 8 1914, to Jany 11 1914, that I last saw her alive on Jany 10 1914 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 7 yrs. 5 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James R Stewart M. D.

19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 3 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Dry Buck Boise Co Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill

DATE OF BURIAL: 1/16 1914

20. UNDERTAKER: Schreiber & Sidenfaden

ADDRESS: Boise Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 17029
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 613½ Idaho St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alejo Allegria

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: July (Month) 17 (Day) 1866 (Year)

7. AGE: 47 yrs. 5 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ullibarri Spain

10. NAME OF FATHER: Fidel Allegria

11. BIRTHPLACE OF FATHER (State or Country): Ullibarri Spain

12. MAIDEN NAME OF MOTHER: Non o Hannabe

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mateo Arregui
(Address) Boise Idaho

15.
Filed 1-13 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Jan 12 1914, that I last saw h.m alive on Jan 12 1914, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Amyloid degeneration of heart

(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Eve Coconat M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: Jan 14 1914

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7030

Registered No. 16

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.....

Primary Registration District No.....

(No. St. Alphonsus Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jonathan Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 25 (Day) 1843 (Year)

7. AGE: 69 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Thomas. Cox.

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Rachel. Jay.

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Cox.

(Address) R.F.D. 4 Boise Idaho.

15. Filed 1-13- 1914 J.H. Baker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Jan 11 1914, that I last saw h[illegible] alive on Jan 10 1914, and that death occured on the date stated above, at 6-15 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jas. Attenger M. D.

1/11 1914 (Address) Falk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan 13 1914

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8 7032

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 110 Front Bannock St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Steely

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't know

6. DATE OF BIRTH: not obtainable. [redacted] (Month) (Day) [illegible] (Year)

7. AGE: 54 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Telegraph Operator at one time.

(b) General nature of industry business, or dstablishment in which employed (or employer): Lineman or Watchman during last years of life.

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Watt Pierce

(Address) 3, 4 Overland Bldg.

15.

Filed 1-9 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Jan 3 1914, that I last saw h[illegible] alive on Jan 3 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) yrs. mos. ds.

Contributory (Secondary): Alcoholism

(Duration) yrs. mos. ds.

(Signed) R. K. Glenn M. D.

1/7 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence: Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 9 1914

20. UNDERTAKER: Thurber & Anderson | ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7032

Name Charles Steely

Date of Death Jan. 3. 1914

Cause of Death Pulmonary Intussusception

Contributary Cause of death

(Sign here) [illegible] M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 7703

Registered No.

County of Ada

City of Boise (No. 21 N. 4th & Denver St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Frank Nixon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: Jan 5th 1913 (Month) (Day) (Year)

7. AGE: 1 yrs. — mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Fred B. Nixon

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Esie Dipon

13. BIRTHPLACE OF MOTHER (State or Country): Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. B. Nixon
(Address) Boise, Ida.

15. Filed 1—10 1914 M. O. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 10 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1913, to Jan 10 1914, that I last saw h~~im~~ alive on Jan 9 1914, and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:
Pneumonia - Lobular type

(Duration) yrs. 1 mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. N. Hallman M. D.

1/10 1914 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 12 1914

20. UNDERTAKER: Schreiber & Hedenstad | ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 70346
Registered No.

PLACE OF DEATH.
County of Ada.
City of Boise
If death occurs away from usual residence, give facts called for under special information. 2.

Registration District No. 2
Primary Registration District No. 1004
(No. 1, = River St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Viola M. Huttable

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: January (Month) 5 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Boise Idaho.

10. NAME OF FATHER Geo Huttable

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Edith Benson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D R Benson
(Address) Boise Ida.

15. Filed 1-7 1914 M O Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8 A M. 191 , to 7 P M. 1-6 1914, that I last saw her alive on Jan 6 1914 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Diffiault birth

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. E. Troop M. D.
1-6 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Boise — DATE OF BURIAL: 1-6-1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4
Registered No. 705

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2
Primary Registration District No. 1004.

County of Ada
City of Boise
(No. 1004, N. 18th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Robb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Married

6. DATE OF BIRTH: Dec (Month) 28th (Day) 1864 (Year)

7. AGE: 49 yrs. 0 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Woolraiser
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spacney Scotland

10. NAME OF FATHER: Alex. Robb.

11. BIRTHPLACE OF FATHER (State or Country): Scottand

12. MAIDEN NAME OF MOTHER: [illegible] Janet Muley

13. BIRTHPLACE OF MOTHER (State or Country): Scottand.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Elliott
(Address) Boise

15. Filed 1-6 1914 W. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1913, to Jan 5 1913 that I last saw him alive on Jan 4 1913 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:
Uremia with Convulsions
(Duration) Several hours ds.
Contributory (Secondary) Chronic interstitial nephritis
(Duration) 12 yrs. mos. ds.

(Signed) [illegible] M. D.
1-5 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence 1004 N. 18th Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 1/6 1914

20. UNDERTAKER: Schreiber & Siedenfaden | ADDRESS: Boise, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 7037

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 417, Wash St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward M Helm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: Mar (Month) (Day) 1871 (Year)

7. AGE: 42 yrs. 10 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling Salesman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cube. Mo.

10. NAME OF FATHER: Wm H Helm

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Emma Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E C Helm
(Address) Boise Idaho

15.
Filed 1-7 1914 WS Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 5th (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1913, to Jan 5 1913, that I last saw h[illegible] alive on Jan 5 1913 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Acute Alcoholism
(Duration) ..... yrs. Several ds.
Contributory (Secondary) Cardiac manifestation
(Duration) Several yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos. 2 days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/7 1914

20. UNDERTAKER: Schreiber & Sidwaden — ADDRESS: Boise, Idaho

Titus

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 112, E. Bannock St.)

File No. 2

Registered No. 703

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Otis Matthews

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 17th (Day) 1898 (Year)

7. AGE: 15 yrs. 11 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. D. Matthews

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: E. L. Lakton

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Matthews
(Address) Van Wyoke Idaho

15.
Filed 1 – 6 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1913, to Jany 4 1914, that I last saw h— alive on Jany 4 1914, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Typhoid Perforation

(Duration) ... yrs. ... mos. 10 ds.

Contributory (Secondary) Pleurisy appendix

(Duration) ... yrs. ... mos. 10 ds.

(Signed) Samuel Olmstead M. D.

1/6 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 10 days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence. Van Wyoke, Idaho

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: 1/6 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jamo Jc.
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 621, Dos St.)

File No. 3701
Registered No. 123

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ed. Berks Poppleton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH
Feby (Month) 27 (Day) 1874 (Year)

7. AGE
39 yrs. 10 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry business, or dstablishment in which employed (or employer) Machinist

9. BIRTHPLACE (State or Country) Belleville Utah

10. NAME OF FATHER Wm Poppleton

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Leah Berks.

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Drake
(Address) Pocatello Ida

15. Filed Jan 7 1914 O P Treat Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jany (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191[illegible], to Jany 2 1914, that I last saw him alive on Jany 2 1914, and that death occurred on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O P Treat M. D.
Jan 2 1914 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
Belleville Utah Jan 7 1914

20. UNDERTAKER W. H. Walker | ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS—YORK CO., PTRS. & EDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 761
File No. 3042
Registered No. 124

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. ....., Pocatello Gen. Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Agnes Cheney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Feby (Month) 8 (Day) 1885 (Year)

7. AGE: 28 yrs. 10 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Joe. Reed

11. BIRTHPLACE OF FATHER (State or Country): Birmingham Ala

12. MAIDEN NAME OF MOTHER: Mollie Holloway.

13. BIRTHPLACE OF MOTHER (State or Country): Alabama.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Cheney
(Address) Pocatello Ida

15. Filed Jany 7 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1913, to Jan 2 1914, that I last saw h.. alive on Jan 2 1914, and that death occurred on the date stated above, at 11.30 M.

The CAUSE OF DEATH* was as follows:
Peritonitis following injected uterus

(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Myocarditis
(Duration) ..... yrs. several mos. ..... ds.

(Signed) Dr A-M. Newton M. D.
19 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida — DATE OF BURIAL: 6 Jany 1914

20. UNDERTAKER: M. M. Nelson — ADDRESS: Pocatello Ida

SYMS - YORK CO., PTRS. & SDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 412 N. 5th St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
File No. 3704
Registered No. 135

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mathilda A Kelly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White Female
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 16 1841 (Month) (Day) (Year)

7. AGE: 72 yrs. 2 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Isle of Man

10. NAME OF FATHER: Wm Kelly

11. BIRTHPLACE OF FATHER (State or Country): Isle of Man.

12. MAIDEN NAME OF MOTHER: Jane Gill

13. BIRTHPLACE OF MOTHER (State or Country): Isle of Man

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Kelly
(Address) Pocatello

15. Filed Jany 5 1914 O. F. Neely Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jany 5 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 2 1914 to Jany 5 1914
that I last saw her alive on Jany 5 1914
and that death occurred on the date stated above, at 8 1/2 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (Secondary) Mitral Insufficiency

1/5/14 (Duration) Several years yrs. mos. ds.

(Signed) J. M. Lang M. D.

19 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: Jany 8 1914

20. UNDERTAKER: W. S. Ballard — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 628, So Arthur St.)

File No. 7044
Registered No. 156
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva V. Fridenstine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Dec. 23 1882 (Month) (Day) (Year)

7. AGE: 31 yrs. mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John Esterly

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Fridenstine
(Address) Pocatello

15. Filed Jany 5 1914 W B Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jany 5 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2 1914, to Jan. 5 1914, that I last saw her alive on Jan. 5 1914, and that death occurred on the date stated above, at 10 15 a. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) — yrs. — mos. 3 ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) W. F. Howard M. D.
1 / 20 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Cemetery — DATE OF BURIAL: Jany 7th 1914

20. UNDERTAKER: M Macfarlane — ADDRESS: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STNRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Ore Town at
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 7045
Registered No. 127
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Marsella White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): ~~Married~~

6. DATE OF BIRTH: June (Month) 26 (Day) 1909 (Year)

7. AGE: 4 yrs. 6 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chester Ida

10. NAME OF FATHER: Geo White

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rhoda Saunders

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo White
(Address) Harrisville Ida

15. Filed Jany 7 1914 O F Neely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 7 (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191., to ✓ 191
that I last saw her alive on ✓ 191,
and that death occurred on the date stated above, at 1. P. M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E N Robb M. D.
Jany 7 1914 (Address) Preca Fells Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Custer Ida — DATE OF BURIAL: Jany 7 1914

20. UNDERTAKER: T. M. Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STEVENS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 314

File No. 3704

City of Pocatello (No. 530 N Garfield St.)

Registered No. 139

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nacie Mooney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb 12 (Month) (Day) 1869 (Year)

7. AGE: 44 yrs. 11 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Jonas Bryant

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Callie Lewallyan

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W.A. Zetsche
(Address) City

15. Filed Jan 17 1914 O. P. Straight Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 16 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7 1914 to Jan 16 1914
that I last saw her alive on Jan 16 1914
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) Few months.

Contributory (Secondary) Hypostasis of Lungs.

(Duration) 7 days.

(Signed) F. M. Kay M. D.

19 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View DATE OF BURIAL: Jan 19 1914

20. UNDERTAKER: Crawford Schumacher ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-1612

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 14

County of Bannock Primary Registration District No. 67 File No. 4048

City of Pocatello (No. Gen. Hospital St.) Registered No. 130

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lida Miller

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH: July (Month) 11 (Day) 1883 (Year)

7. AGE: 30 yrs. 6 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nunca Ut. Co.

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phil James Miller
(Address) Nampa

15. Filed Jany 25 1914 F B Steen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jany (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19th 1914, to Jan 24th 1914, that I last saw h er alive on Jany 24 1914 and that death occurred on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) Unknown yrs. mos. ds.

(Signed) W. A. Wright M. D.

1/24 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 2 mos. 7 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? Don't Know

Former or usual residence Nampa Idaho

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: Jany 29 1914

20. UNDERTAKER: F. B. Walker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 123 S. Arthur St.)
If death occurs away from usual residence, give facts called for under special information.
File No. 3404
Registered No. 131
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adeline Brannon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 12 (Month) 21 (Day) 1888 (Year)

7. AGE: 25 yrs. 1 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Ida~~ Golden Colo

10. NAME OF FATHER: A J Porter

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lottie York

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Brannon
(Address) 128 S Arthur Pocatello

15. Filed Feby 2 1914 O P Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 31 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15th 1914, to Jan 31 1914, that I last saw her alive on Jan 31. 1914 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) 7 yrs. 3 mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O P Lee M. D.
31 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Castle Colo — DATE OF BURIAL: Feby 4 1914

20. UNDERTAKER: Crawford and Berry — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & PBRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1071

File No. 7050

City of Wallace

(No. Wallace Hospital St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Sari,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: May (Month) 15 (Day) 1880 (Year)

7. AGE: 33 yrs. 7 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: John Sari

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Anna Kumr

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac Bowman

(Address) Mullan, Idaho.

15. Filed Jan 3 191 4 F. Leo Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1914 to Jan 2 1914 that I last saw h~~im~~ alive on Jan 2 1914 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 0 yrs. 0 mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Curtis Bland M. D.

Jan 3 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. X yrs. X mos. In the State. 0 yrs. 5 mos. 0 days.

Where was disease contracted if not at place of death? Mullan Idaho

Former or usual residence Mullan, Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho

DATE OF BURIAL: Jany 4 1914

20. UNDERTAKER: Bruce G Worstell

ADDRESS: Wallace. Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 40
Primary Registration District No. 1011
(No. 9 St.)

File No. 7051
Registered No. 8
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME D H Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
51 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer) Bunker Hill Cleveland Mine

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Hester
(Address)

15.
Filed Jan. 19 1914 H. Lee Tuttle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture Skull

(Duration) Few Mins yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) D. H. Mowry M. D.
Feb 6 19 14 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hunford Texas	Jan 20 1917
20. UNDERTAKER	ADDRESS
D V Woodall	Wallace

W K Bain

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 7052
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fredrick James Sparks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
57 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) New Brunswick Canada

10. NAME OF FATHER Daniel Sparks

11. BIRTHPLACE OF FATHER
(State or Country) Canada

12. MAIDEN NAME OF MOTHER Elinor Walker

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas E Sparks
(Address) Missoula Montana

15.
Filed Jan 7 1914 W. F. Leo Jungley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 4 1914, to January 4 1914, that I last saw h.im alive on January 4 1914, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Probably Intoxication
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. Brown M. D.
19 ..... (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. 4 hours
Where was disease contracted if not at place of death? St Regis Montana
Former or usual residence St Regis Montana

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
Missoula Mont | Jan 7 1914

20. UNDERTAKER | ADDRESS
Hook Undertaking Co | Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 7055
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Riordan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	widow

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
89 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary A Riordan
(Address) Spokane Wash

15.
Filed Jan 17 1914 F. Leo Langley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914, to Jan 17 1914, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

General debility

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) F. Leo Langley M. D.
1/17 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cedar Grove Wash.	Jan 19 1914

20. UNDERTAKER	ADDRESS
Ward Undertaking	Wallace

2da

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Shoshone
City of Wallace
(No. ....., ... St.)

Registration District No. 70
Primary Registration District No. 1011

File No. 705
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Finley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
20 yrs. 10 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Book Keeper.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New Foundland

10. NAME OF FATHER J J Finley

11. BIRTHPLACE OF FATHER (State or Country) New Foundland

12. MAIDEN NAME OF MOTHER Charlotte McCodin

13. BIRTHPLACE OF MOTHER (State or Country) New Foundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Bess Finney, Burke Idaho

15.
Filed Jan. 20 1914 H. Leo Dingle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 18 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1913, to Jan 18 1914,
that I last saw her alive on Jan 18 1914
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Endocarditis Malignant
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D W Mowery M.D.
Jan 20 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Idaho	Jan 21 1914

20. UNDERTAKER	ADDRESS
Ward Undertaking Co	Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. ..... St.)

File No. 7056
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Elason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
40 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) unknown

10. NAME OF FATHER
"

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER
"

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Harry Thompson
(Address) Wallace Ida

15.
Filed Jan. 20 1914 F. Leo Dunphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Fractured Skull

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas R Mowbray M.D.
Jan 20 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	Jan 21 1914

20. UNDERTAKER ADDRESS
Ward Undertaking Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

of Blaine

Soldier

(No. ....., ... St.)

Registration District No. 58

Primary Registration District No. 2138

File No. 105

Registered No. 1

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

urs away from usu- give facts called ecial information.

2. FULL NAME Chester Moyer

RSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

BIRTH

July (Month) (Day) 1912 (Year)

IF LESS than 1 day how many ..... hrs. or ..... min.?

..... yrs. ..... mos. ..... ds.

8. OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Viola Neal

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. E. Moyer

(Address) Soldier

15.

Filed 2-20-1914 D O Huggins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-7-1914, to 2-14-1914 that I last saw him alive on 2-14-1914, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D O Huggins M. D.

2-20 1914 (Address) Soldier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soldier Ida

DATE OF BURIAL: 2-21-1914

20. UNDERTAKER: Big Moore

ADDRESS: Fairfield

WRITE PLAINLY, WITH UNFADING INK—MARGIN RESERVED FOR

N. B.—Every item of information should be carefully supplied. CIANS should state CAUSE OF DEATH in plain terms, so ment of OCCUPATION is very important. See instruction

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136.

File No. 705
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christine M. Payne

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 12th 1912 (Month) (Day) (Year)

7. AGE: 1 yrs. 10 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Row, Oklahoma

10. NAME OF FATHER: S. D. Payne

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Anna Birchfield

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. D. Payne
(Address) Twin Falls, Idaho

15.
Filed 2/11/ 1914 H. H. Reiz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 11th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
12 hours.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Bronchial Asthma
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. D Payne M. D.
19.... (Address) Father

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days. 12 hrs.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Feb. 12th 1914

20. UNDERTAKER: L. C. Tucker — ADDRESS: Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

State of Idaho,

County of Bear Lake. ss.

I, S. B. Payne, of Pryor, Okla., depose and say; that I am the father of Christine Payne, aged two years; that said child died in route at or near Kemmerrer, Wyoming, on Train No. 5 Oregon Short Line Railroad, on February 11th, 1914, about 5 a. M., and that said child had been in ordinary health except that it was suffering from a chronic bronchial asthma following an attack of whooping cough contracted a year previous to its death. That at the time of death there was no physican in attendance and that to the best of my knowledge and belief the child died from heart failure caused by the extreme altitude and that not to my knowledge had the child been exposed or was it suffering from any contagious desease.

S. B. Payne

Subscribed and sworn to before me this 11th day of Feb., 1914.

D. McKinney

Notary Public

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH,
County of Bear Lake
City of Raymond
(No. ....., ... St.)

Registration District No. 52
Primary Registration District No. 2136
File No. 705
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Antonia Mumford.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH [illegible] (Month) 26 (Day) 1887 (Year)

7. AGE 26 yrs. 10 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER George Bleckert

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Mary Porchawite

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos. M. Mumford
(Address) Montpelier Idaho

15. Filed 2/14/1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 12th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12th 1914 to Feb. 12th 1914
that I last saw her alive on Feb. 12th 1914
and that death occurred on the date stated above, at 11½ M.

The CAUSE OF DEATH* was as follows:
Diabetic Coma
(Diabetes Mellitus)
(?)
(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lon Poyner M. D.
2/14/1914 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 23 yrs. ..... mos. ..... days. In the State 23 yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL Montpelier, Ida. DATE OF BURIAL Feb 15 1914

20. UNDERTAKER Vincent Bros. ADDRESS Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1067
Registered No. 9

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2195
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susie Thiessen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1901 (Year)

7. AGE: 12 yrs. 11 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Peter Thiessen

11. BIRTHPLACE OF FATHER (State or Country): South Russia

12. MAIDEN NAME OF MOTHER: Justina Friesen

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Thiessen
(Address) Aberdeen Ida

15. Filed Feb 10 1914 M. C. Martinson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1914, to Feb 9 1914
that I last saw her alive on Feb 9 1914
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage.

..... (Duration) — yrs. — mos. 9 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. C. Martinson M. D.
Feb 10 1914 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mennonite Cemetery
DATE OF BURIAL: Feb 12 1914

20. UNDERTAKER (Acting): Peter Thiessen
ADDRESS: Aberdeen Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 7065
Registered No. 14

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Palmer Gustavson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1895 (Year)

7. AGE: 19 yrs. 1 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Gus Gustavsen

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Svardal

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stephen Cunningham
(Address) Moscow Idaho

15. Filed Feb 28 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1914., to Feb 26 1914., that I last saw h in alive on Feb 26 1914, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Inflammatory Rheumatism & Chronic Endocarditis
(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Rheumatic heart failure & endocarditis
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) F W Leetch M. D.
2/27 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: March 1 1914

20. UNDERTAKER: Leo Stitz | ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
(No. ..... , ... St.)

File No. 1062
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nels E. Berglund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Married

6. DATE OF BIRTH
May (Month) 8 (Day) 1849 (Year)

7. AGE
64 yrs. 9 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norland sweden

10. NAME OF FATHER Nels Nelson

11. BIRTHPLACE OF FATHER (State or Country) Norland sweden

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Berglund
(Address) Moscow

15. Filed [redacted] 191[redacted] J. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191 , to ——— 191 ,
~~that I last saw h alive on~~ ——— 191 ,
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Died suddenly probably Apoplexy

(Duration) ——— yrs. ——— mos. ——— ds.
Contributory (Secondary) None known
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Aspray M. D.
Feb 9 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	Feb 12 1914
20. UNDERTAKER Geo Stolz	ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 7063
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ebenezer Herring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 29 (Day) 1840 (Year)

7. AGE: 74 yrs. 8 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary C. Stubs

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Herring
(Address) Genore Idaho

15. Filed Feb 9 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 9" E. E. Herring (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31" 1914, to Feb. 9" 1914, that I last saw him alive on Feb 8" 1914, and that death occurred on the date stated above, at 6-10 A.M.

The CAUSE OF DEATH* was as follows:

Cystitis

(Duration) 3 yrs. mos. ds.

Contributory (Secondary): Enlargment of Prostate

(Duration) yrs. mos. ds.

(Signed) W. H. Gaither M. D.

Feb 9 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 9 days. In the State 19 yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? Cavendish Idaho.

Former or usual residence Cavendish Idaho.

19. PLACE OF BURIAL OR REMOVAL: Clearwater Caem | DATE OF BURIAL: Feb 10 1914

20. UNDERTAKER: Geo Stetz | ADDRESS: Moscow.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011

File No. 7064
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Jinnett Savage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F. W.	W	~~Single~~ Married

6. DATE OF BIRTH: March (Month) 29 (Day) 1901 (Year)

7. AGE: 12 yrs. 10 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Dayton Wash

10. NAME OF FATHER Geo. Savage

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Ethel Jinnett

13. BIRTHPLACE OF MOTHER (State or Country) Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Geo. Savage
(Address) Moscow

15. Filed Feb 20 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17 1914, to Feby 18 1914, that I last saw her alive on Feb. 18, 1914, and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:
Nephritis Chronic
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Predisposing cause Diphtheria 3 yrs ago
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. E. Gutman M. D.
2/19 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Feb 21 1914

20. UNDERTAKER: Gus Skelly — ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7064

Name Laura Jinnett Savage

Date of Death Feb. 18. 1914

Cause of Death Syphilis. Chronic.

Contributary Cause of death Diphtheria

(Sign here) Chas L. Guilleaume M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1065
Registered No. 10

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Binder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	widowed

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
65 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Stelz
(Address) Moscow

15. Filed Feb 5 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan Feb 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1914, to Jan Feb 5 1914 that I last saw h-r alive on Feb 2 1914 and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Senile Gangrene

(Duration) ..... yrs. 5 mos. ..... ds.
Contributory (Secondary) Old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.
19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Moscow | DATE OF BURIAL Feb 6 1914

20. UNDERTAKER Geo Stelz | ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1067
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
(No. , St.)
Registration District No. 38
Primary Registration District No. 2086
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James C Dexter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: May (Month) 13 (Day) 1866 (Year)
7. AGE: 47 yrs. 9 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: Geo Dexter
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Alice Croak
13. BIRTHPLACE OF MOTHER (State or Country): England.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Dexter
(Address) Filer Ida
15. Filed Feb 21 1914 A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 20 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw him alive on Feb 13 1914
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A A Newberry M. D.
2-21 1914 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery
DATE OF BURIAL: 2-24 1914
20. UNDERTAKER: J J Crosby
ADDRESS: Twin Falls Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7067

Name James C. Dexter

Date of Death Feb. 20, 1914

Cause of Death Tuberculosis

Contributary Cause of death

(Sign here) A A Newberry M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1065
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Filer

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Creasey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Feb. 13 1914
(Month) (Day) (Year)

7. AGE: 1st about yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Lincolnshire England

10. NAME OF FATHER: Locking Skelton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary S Kelton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Creasey
(Address) Filer

15. Filed Feb. 14 1914 A A Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 13 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13 1914, to ..... 191—
that I last saw her alive on Feb 13 1914
and that death occurred on the date stated above, at 11.40 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A Newberry M. D.
Feb 14 1914 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery
DATE OF BURIAL: Feb 16 1914

20. UNDERTAKER: Crosby
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

File No. 7069
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florin Alla Wooldridge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: 11 (Month) 15 (Day) 1850 (Year)

7. AGE: 63 yrs. 7 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Christian Co. Ky

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Darrell Wooldridge Son
(Address) Kendrick Idaho

15.
Filed Feb 11 1914 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1914, to Feb 10 1914, that I last saw him alive on Feb 10 1914, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.
Contributory Bronchitis
(Secondary)
(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) J E Hoyt M. D.
Feb 11 1914 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Little Bear Ridge Cemetery
DATE OF BURIAL: Feb 12 1914

20. UNDERTAKER: D. J. Rowlands
ADDRESS: Kendrick Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1079
Registered No. 3

1. PLACE OF DEATH.
County of Latah
City of Kendrick

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Hill.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April 13 1905
" " Death: Jan 4 1914
(Month) (Day) (Year)

7. AGE: 8 yrs. 9 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: school girl
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kendrick Ida

10. NAME OF FATHER: Henry M Hill

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Martha J Robinet

13. BIRTHPLACE OF MOTHER (State or Country): Kas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H M Hill
(Address) Kendrick Ida

15.
Filed Feb 11 1914 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1913, to Jan 4 1914
that I last saw her alive on Jan 3 1914
and that death occurred on the date stated above, at 2-9 M.

The CAUSE OF DEATH* was as follows: Valvular disease of the heart. Mitral insufficiency.

(Duration) 5 yrs. mos. ds.

Contributory (Secondary) Influenza Rheumatism

(Duration) 5 yrs ago yrs. mos. ds.

(Signed) Wm. Rothwell M. D.

Jan 4 1914 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Kendrick Ida Co
DATE OF BURIAL: Jan 6 1914

20. UNDERTAKER: D J Rowlands
ADDRESS: Kendrick Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36
Primary Registration District No. 2084
(No. ....., ... St.)

File No. 1071
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriett M Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	Married

6. DATE OF BIRTH
July (Month) 21 (Day) 1884 (Year)

7. AGE
29 yrs. 7 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... House Wife.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Hugh C. Hawk.

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Ella M Blake

13. BIRTHPLACE OF MOTHER (State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel A. Merritt
(Address) Kimberly.

15. Filed 2 March 1914 John J White
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1914, to Mar 4 1914, that I last saw h.er alive on Mar 4 1914, and that death occurred on the date stated above, at 4:30 M. P.

The CAUSE OF DEATH* was as follows:
Puerperal Eclampsia
(Duration) ..... yrs. ..... mos. 1/4 hr. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.
Mar 4 1914 (Address) Kimberly, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Carroll Ill — DATE OF BURIAL: ..... 191..

20. UNDERTAKER: J. J. Freeman — ADDRESS: Twin Falls

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53 53-
Primary Registration District No. 24
File No. 1073
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas J. Rich.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 9 (Day) 1878 (Year)

7. AGE: 35 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Charles, Ida

10. NAME OF FATHER Thomas Rich

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake Utah

12. MAIDEN NAME OF MOTHER Elezabeth Lucmiere

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Chas Brewer
(Address) St Charles, Ida

15.
Filed Feb 16 1914 John Mattson
Local Registrar

SYMS - YORK CO., PTRS. & RGRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1914, to July 10 1914, that I last saw him alive on July 10 1914, and that death occured on the date stated above, at 9 30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorhage
of Apoplexy.
5 minutes (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Rich M. D.
7/11 1914 (Address) Paris, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles — DATE OF BURIAL: Feb 13 1914

20. UNDERTAKER: J. A. Blades — ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No.
File No. 7074
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles (No. ..., Dorthea St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Mattson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb 6 1914 (Month) (Day) (Year)

7. AGE: 28 yrs. ... mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Charles

10. NAME OF FATHER: Ola Mattson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Josephene Anderson Mattson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hannah Nelson
(Address) St Charles

15. Filed Feb 9 1914 John Mattson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: ~~Feb~~ Jan 20 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191...,
that I last saw h... alive on ... 191...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Hart Failure
Dr Has moved away
(Duration) ... yrs. ... mos. ... ds.
~~Contributory~~ That was in attendance
(Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) ... M. D.
19... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles | DATE OF BURIAL: Jan 23 1914

20. UNDERTAKER: J a Blende | ADDRESS: St Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy", "Collapse," "Coma," "Convulsions," "Debility, ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

N # 6

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7076
Registered No. 10

1. PLACE OF DEATH.
County of Bannock
City of
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2046

2. FULL NAME Ethel Coffin

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 22 (Day) 1891 (Year)

7. AGE: 22 yrs. 10 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cambridge Idaho

10. NAME OF FATHER: H H Coffin

11. BIRTHPLACE OF FATHER (State or Country): Oxford Idaho

12. MAIDEN NAME OF MOTHER: Mary C Merrill

13. BIRTHPLACE OF MOTHER (State or Country): Preston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Coffin
(Address) Downey Idaho

15. Filed Feb 10, 1914 Eric Kaeser Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1914, to Feb 2 1914, that I last saw her alive on Feb 2 1914, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary hemorrhage

(Duration) 3 yrs. mos. 3 ds.
Contributory Pulmonary Tuberculosis
(Secondary)
(Duration) 2 yrs. mos. ds.

(Signed) Chas Powell M. D.
Feb 3 1914. (Address) Downey, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Cemetery | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: E E Layton | ADDRESS: Downey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V[redacted]12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1085

Registered No. 7

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. [redacted]E OF DEATH

County of Bannock

City of Mc Cammon

Registration District No. 11

Primary Registration District No. 2047

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Cordelia Warner.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan — 23 — 1874 (Month) (Day) (Year)

7. AGE: 40 yrs. ..... mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min? 9 m/s ½

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: Wm. Gay

11. BIRTHPLACE OF FATHER (State or Country): Don't Know.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Warner
(Address) Dempsey, Ida.

15. Filed Feb 10, 1914 Edis Kaser Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. — 1 — 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — — 191..., to ..... 191...
that I last saw h[illegible] alive on Feb 1st 1914
and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. H. Cooper M. D.

19..... (Address) Mc Cammon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dempsey — DATE OF BURIAL: Feb 4 1914

20. UNDERTAKER: [illegible] Sullivan — ADDRESS: Dempsey

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7081
Registered No. 6

1. PLACE OF DEATH.
County of Bannock.
City of McCammon
(No. ....., ... St.)

Registration District No. 11
Primary Registration District No. 2047

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Edward Parse

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct — 5th (Month) (Day) 1825. (Year)

7. AGE: 38 yrs. 9 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bucklin - Mo.

10. NAME OF FATHER: James K. Parse.

11. BIRTHPLACE OF FATHER (State or Country): Penn —

12. MAIDEN NAME OF MOTHER: Cook.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. W. M. Parse
(Address) McCammon Ida.

15. Filed Jan 10, 1914 Edith Keeney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan — 18 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18 1914, to Jan 18 — 1914
that I last saw h[illegible] alive on Jan 18th 1914
and that death occurred on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
Following Measles
(Duration) ..... yrs. ..... mos. 14 — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G H Colpin — M. D.
1/3 — 1914 (Address) McCammon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Robin Ida.
DATE OF BURIAL: 1/21 — 1914

20. UNDERTAKER: G H Dewey
ADDRESS: Dewey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7081

Name James Edward Perse

Date of Death Jan. 18, 1914

Cause of Death Lobar-Pneumonia

Contributary Cause of death Measles

(Sign here) G. A. Cooper M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of Bannock

Primary Registration District No. 2048

File No. 7082

City of Soda Springs (St.)

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H Feeney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug 15 (Month) 1825 (Day) (Year)

7. AGE: 89 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: H Feeney

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Hanlen

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Carrigan
(Address) Soda Spirngs Ida

15.
Filed Feb 10, 1914 Ellis Kerley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 18 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1911, to Jan 18th 1914, that I last saw him alive on Jan 15 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 6 yrs. mos. ds.

Contributory (Secondary) Dropsy

(Duration) yrs. mos. ds.

(Signed) Ellis MacKley M. D.

Jan 17th 1914 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: Jan 20 1914

20. UNDERTAKER: O. A. Schumacher — ADDRESS: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7085

Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Andrew Leo Arrett

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 13 (Day) 1893 (Year)

7. AGE: 20 yrs. 7 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Horse.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington Utah.

10. NAME OF FATHER: G H Arrett.

11. BIRTHPLACE OF FATHER (State or Country): Washington Utah.

12. MAIDEN NAME OF MOTHER: Joe Hanna Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Arrett
(Address) Buhl

15.
Filed 2-12 1914
J. Mcnerney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~~~ 191..., to ~~~~ 191...,
that I last saw h... alive on ~~~~ 191...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 15 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Mcnerney M. D.
2-12 1914 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer. DATE OF BURIAL: 2-13 1914

20. UNDERTAKER: None ADDRESS:

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of C. D. A.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1150
(No. ....., ... St.)

File No. 1
Registered No. 38
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Weeks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 21 (Day) 1861 (Year)

7. AGE: 52 yrs. 11 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: McConnell

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Kennedy

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas A. Weeks
(Address) Coeur d. Alene

15. Filed 2-27 1914 M. A. Norland Local Registrar
Idaho

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 1914, to Feb. 22 1914, that I last saw h. Ex alive on Feb. 22 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Angina pectoris.

(Duration) 1 yrs. 6 mos. ..... ds.
Contributory (Secondary) Arteria - sclerosis.
(Duration) unknown yrs. ..... mos. ..... ds.

(Signed) John D. Wood M. D.
Feb. 23 1914 (Address) Coeur D'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Feb 25 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050
File No. 7087
Registered No. 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie B Langdon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
June (Month) 22 (Day) 1887 (Year)

7. AGE
31 yrs. 7 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Wm Carl

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Bradsley

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Langdon
(Address) Coeur d'Alene

15.
Filed 2-27 1914 M R Dalton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. 17 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19 1914, to Feb. 17 1914, that I last saw h[illegible] alive on Feb 17 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Flynn M. D.
Feb 28 1914 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary | DATE OF BURIAL: Feb 24 1914

20. UNDERTAKER: Cassedy & Nelson | ADDRESS: Coeur D'Alene

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 7089
Registered No. 37

1. PLACE OF DEATH.
County of Kootenai
City of Rosedale Ely (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Henry J. Miller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... 1 ..... (Month) (Day) (Year)

7. AGE: 53 yrs. 5 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Stock Man
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) ✓

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Wentworth M.D.
(Address) Rosedale Ely

15.
Filed 2-27 1914 Mary Ford
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby 26 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191....
that I last saw h... alive on ..... 191....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. E. Wentworth M. D.
2/27 1914 (Address) Rosedale Ely

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191....

20. UNDERTAKER: Wrstell, | ADDRESS: Kellogg

Kellogg Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7090
Registered No. [illegible]

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. ....; ....St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilbur Wayne Tyree

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Oct (Month) 28 (Day) 1914 (Year)
7. AGE: ....yrs. 4 mos. 27 ds. IF LESS than 1 day how many ....hrs. or ....mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work ....
(b) General nature of industry business, or dstablishment in which employed (or employer) ....
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: Oliver C. Tyree
11. BIRTHPLACE OF FATHER (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Edna Thayer
13. BIRTHPLACE OF MOTHER (State or Country): Minn.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O C Tyree
(Address) ....
15. Filed 2-5 1914 W A Woodard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 3rd (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 26th 1914, to Feb 3rd 1914, that I last saw h[illegible] alive on Feb 3rd 1914, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
whooping cough
....
....
(Duration) ....yrs. 1 mos. 6 ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) John Hunt Tuttle M. D.
2/5/1919 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?....
Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Feb 5 1914
20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified; is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy", "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Kootenai
City of Coeur D Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29.
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 7091
Registered No. 18
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac D Sands

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
8 15 1
(Month) (Day) (Year)

7. AGE
40 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Cruiser (Timber)
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Main

10. NAME OF FATHER Sands

11. BIRTHPLACE OF FATHER (State or Country) Main

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E F McMahon
(Address) Coeur D Alene Ida

15.
Filed 2-6 1914 Mor C Dobson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1914, to Feb 5 1914, that I last saw h[im] alive on Feb 5 1914, and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Penitentiary Perforated Gastric Ulcer

(Duration) ..... yrs. mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. C. Byrns M. D.
Feb 5 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Thomas Cem.	Feb 6 1914

20. UNDERTAKER	ADDRESS
Cassedy & Nelson	Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29.
Primary Registration District No. 105.0

File No. 7092
Registered No. 20
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillian Swartz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
..... (Month) ..... (Day) 1871 (Year)

7. AGE
42 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Dont Know

10. NAME OF FATHER Mr St Clair

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Great Swartz
(Address) .....

15. Filed 2-2- 1914 Max R Borland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2- 2. 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Feb 2 1914
that I last saw h[illegible] alive on 2-2 1914
and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:
Mitral segregitation
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Max R[illegible] D.
2-2 1914. (Address) CdAlene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Feb 3 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

File No. 7093

Registered No. 27

County of Kootenai

City of Carlin Bay P.O. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsa Krueger

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Sept (Month) 28 (Day) 1912 (Year)

7. AGE: 1 yrs. 4 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Coeur D'Alene

10. NAME OF FATHER Edward Krueger

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Emilia Hilgalke

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Conrad Krueger

(Address) Carlin Bay

15.

Filed 2-17 1914 Dr. MAY A. DORLAND Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 13th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

did not see child or preceede for it - parent says it died of result of diarrhoea

(Duration) 1 yrs. 4 mos. 1 ds.

Contributory (Secondary) Sick few days

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Ruby M. D.

Feb 16 1914 (Address) Coeur d'alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Feb 17 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29.
Primary Registration District No. 1058
File No. 7094
Registered No. 25.

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johnson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	Single

6. DATE OF BIRTH: 2 (Month) 31 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Coeur d'Alene Ida.

10. NAME OF FATHER Daniel Lake Johnson.

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Mathel Henry.

13. BIRTHPLACE OF MOTHER (State or Country) S. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Daniel Lake Johnson
(Address) .....

15. Filed 2-5 1914 Dr. MAX A. DORLAND. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4 1914, to Feb. 7 1914, that I last saw h Er alive on Feb. 7 1914, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Malaena neonatorum.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Elwood M. D.
Feb. 8 1914 (Address) Coeur d'Alene. Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Feb. 9 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 2302
File No. 7095
Registered No. 4

1. PLACE OF DEATH.
County of Ada
City of Eagle
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Colton,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Oct (Month) 24 (Day) 1836 (Year)

7. AGE
78 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter,
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Colton

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Richard Colton
(Address) Eagle Ida

15.
Filed Feb 23 1914
L B Hearn
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 22nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20th 1914, to Feb 22nd 1914,
that I last saw him alive on Jan 20th 1914,
and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:
Senility and
Dilatation of Heart
..... (Duration) — Yrs. — mos. — ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Haynes M. D.
Feb 22 1914 (Address) Eagle Ada

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: Feb 23 1914

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145
(No. , St.)

File No. 709
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel S Stamer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct 12 1849 (Month) (Day) (Year)

7. AGE: 64 yrs. 4 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unofficial

10. NAME OF FATHER: Samuel Stamer

11. BIRTHPLACE OF FATHER (State or Country): Unofficial

12. MAIDEN NAME OF MOTHER: Unofficial

13. BIRTHPLACE OF MOTHER (State or Country): Unofficial

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William S. Stamer
(Address) Potlatch Idaho

15.
Filed March 3rd 1914 D. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 26th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191 , to ✓ 191 , that I last saw h ✓ alive on 191 , and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Accidental Compound fracture of right leg and hemorrhage - caused by log rolling.

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Ordered Burial By M. D.
19 (Address) County Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Mar 3 1914

20. UNDERTAKER: E Anderson — ADDRESS: Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Owyhee

City of Bruneau

Registration District No. 44 —

Primary Registration District No. 2121 —

(No. ....., ... St.)

File No. 709

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A. Plumb

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: June 23 1882 (Month) (Day) (Year)

7. AGE: 32 yrs. 7 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bookkeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: W. D. Plumb

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Dart Knox

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Feb. 10 1914 J. C. Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb — 5 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3rd 1914 to Feb 5 1914 that I last saw h[illegible] alive on Feb 5 1914 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) — yrs. 9 mos. — ds.

Contributory (Secondary) Pulmonary Congestion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Bartlett M. D.

2/6 1914 (Address) Bruneau Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bruneau — DATE OF BURIAL: 2/9 1914

20. UNDERTAKER: Clyde Noble — ADDRESS: Bruneau Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Adams

City of Council

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 2011

(No. ....., ... St.)

File No. 7107

Registered No. 46

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Shirley D. Warner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH

2 (Month) 20 (Day) 1914 (Year)

7. AGE

~ yrs. ~ mos. 4 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Samuel Warner

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Gertrude Smelser

13. BIRTHPLACE OF MOTHER (State or Country) U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel W. Warner

(Address) .....

15.

Filed 3-5- 1914 Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1914, to Feb 24 1914, that I last saw h~~im~~ alive on Feb 23 1914, and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Kidney

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E. Brown M. D.

3-5- 1914 (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Council Ida	2-25- 1914

20. UNDERTAKER	ADDRESS
Robt J Lamm	Council Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 710

Registered No. 68

1. PLACE OF DEATH.
County of Custer
City of Challis

Registration District No. 14
Primary Registration District No. 2061
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Sewell.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Jan 30, (Month) (Day) 1876. (Year)

7. AGE: 37 yrs. 11 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner + rancher.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: John Sewell

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Rebecca Summerville

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Geo. Sewell.
(Address) Challis

15.
Filed 1/13 191 7 C. K. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 12 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1913, to Jan 12 1914
that I last saw h[illegible]alive on Jan 12 1914
and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic parenchymatous nephritis.

..... (Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Kelley M. D.
Jan 13 1914 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. 12 ds. In the State 25 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Stanley, Ida.
Former or usual residence Stanley, Ida.

19. PLACE OF BURIAL OR REMOVAL: Challis
DATE OF BURIAL: Jan 14 1914

20. UNDERTAKER: Friends
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2155
(No. ....., ... St.)

File No. 7104
Registered No. 479
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME W. M. Graham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE: 65 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Brower
(Address) .....

15.
Filed 2-20 1914 M McKenzie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Not known
found dead in his room

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. M Kracht M. D.
1/6 1914 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: 9th Jan 1914

20. UNDERTAKER: E M Brower
ADDRESS: S P

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 7105
Registered No. 480

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John C. Peterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 40 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Pole Maker
(b) General nature of industry business or establishment in which employed (or employer): Woods

9. BIRTHPLACE (State or Country): Probably Wis.

10. NAME OF FATHER: Nels Peterson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Knapp
(Address) Kopan Idaho

15. Filed 1/10 1914 W McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cut throat suicide
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. M. Knapp M. D.
1/7 1914 (Address) Kopa. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Viroqua Wisconsin
DATE OF ~~BURIAL~~: 1/10 1914

20. UNDERTAKER: E M Brower
ADDRESS: S. Front

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 1106
Registered No. 481

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. 717 Ruth St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude McHugh

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 30 (Day) 1909 (Year)

7. AGE: 4 yrs. 7 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry business or establishment in which employed (or employer): do

9. BIRTHPLACE (State or Country): Sandpoint Idaho.

10. NAME OF FATHER: Thomas McHugh

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: Kathrine Welsh.

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas McHugh
(Address) Sandpoint Ida

15.
Filed 2-20 1914 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1914, to Jan 11 1914 that I last saw her alive on Jan 11 1914 and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:
Acute Cardiac dilitation

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.
Jan 12 1914 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lakeview Cem.
DATE OF BURIAL: 1/13 1914

20. UNDERTAKER: E M Rosser.
ADDRESS: S. P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

78 Moody.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7107

Registered No. 482

1. PLACE OF DEATH.
County of Boise
City of Hope.

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. J. Simpson.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
..... 1 .....
(Month) (Day) (Year)

7. AGE: 65 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Hand.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Do.

12. MAIDEN NAME OF MOTHER: Do

13. BIRTHPLACE OF MOTHER (State or Country): Do.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Bray
(Address) R.F.D. No 1

15.
Filed 2-20 1914 M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 9th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9th 1914, to Jan 15 1914
that I last saw him alive on Jan 14 1914
and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Anurism of Innominatum
Haemorrage

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. McKinnon M. D.
Jan 11 1914 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hope
DATE OF BURIAL: 1/21 1914

20. UNDERTAKER: E. M. Brower.
ADDRESS: Sandpoint.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

~~WASHINGTON~~ Idaho STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 7103

File No.

Registered No. 483

PLACE OF DEATH

County of Bonner

City or Town of

Registration Dist. No. 78

Primary reg. no. 2158

(No. , St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

Full Name Helen I Shayer

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Infant

6 DATE OF BIRTH: May 1 (Month) (Day), 1913 (Year)

7 AGE: yrs. 8 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Bonner Co Idaho

PARENTS

10 NAME OF FATHER: Thomas Shayer

11 BIRTHPLACE OF FATHER (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Anna Shirley

13 BIRTHPLACE OF MOTHER (State or country): Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed 2-20, 1914 Mae Kinnear REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 19 (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Jan 19, 1914, that I last saw h.... alive on Jan 11, 1914, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH * was as follows:

Pneumonia Broncho

(Duration) yrs. mos. 8 ds.

Contributory (SECONDARY) Septic inspection of skin

(Duration) yrs. mos. ds.

(Signed) J. R. Phillips, M. D.

Jan 20 1914 (Address) Newport Idaho

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 1914

20 UNDERTAKER: E M Brown | ADDRESS: Sandpoint

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7108

Name Helan I. Strayer

Date of Death Jan. 19, 1914.

Cause of Death Broncho Pneumonia

Contributary Cause of death Exposure following [illegible] formation

(Sign here) J. D. Phillips M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint

Registration District No. 78 Sandpoint
Primary Registration District No. 2155
(No. ..... , ... St.)

File No. 1109
Registered No. 485

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John C. Hauger

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married.

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE 65 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry business or establishment in which employed (or employer): Prospecting.

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Deceased.

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Deceased

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Hauger
(Address) 1127 4th Ave. West Spokane.

15.
Filed 2-20 1914 Mrs. E. Kinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 30th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1914, to Jan 30 1914
that I last saw him alive on Jan 30 1914
and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Gun shot wound of the abdomen

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Taylor M. D.
2-13 1914 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 1/31 1914

20. UNDERTAKER: C. W. Brauer ADDRESS: S.P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 711
Registered No. 48

1. PLACE OF DEATH.
County of Bonner
City of Hope (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Matilda Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F.	White	Married Widowed

6. DATE OF BIRTH: Apr (Month) 4th (Day) 1859 (Year)

7. AGE: 55 yrs. 10 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Larson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Barlena Albery

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John A Carlson
(Address) Hope

15. Filed Feb 6 1914 W. M. McKinnon / Wm Knapp Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26th 1914, to Feb 5 1914, that I last saw her alive on Feb 5 1914, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
Mitral insufficiency
(Duration) two yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm M Knapp M. D.
Feb 6 1914 (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hope — DATE OF BURIAL: 2-7 1914

20. UNDERTAKER: E.M. Brower — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36
Primary Registration District No. 2084
(No. ..... St.)

File No. 7118
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladys Claiborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH
February (Month) 15 (Day) 1914 (Year)

7. AGE
12 yrs. 6 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Payette

10. NAME OF FATHER Ed Claiborn

11. BIRTHPLACE OF FATHER (State or Country) California

12. MAIDEN NAME OF MOTHER Susie Walker

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. F. Moore, Pa Ed Claiborn
(Address) Kimberly, Idaho

15. Filed Feb. 16 1914 John J. White
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9 1914, to Feb. 15 1914, that I last saw h[illegible] alive on Feb. 15 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Meningitis Secondary to Tuberculosis and Tuberculosis meseraic
(Duration) 1 yrs. 1 mos. 14 ds.
Contributory Cerebral Meningitis
(Secondary)
(Duration) ..... yrs. ..... mos. 4 ds.
(Signed) J. M. Davis M. D.
2/16 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Feb. 17 1914

20. UNDERTAKER: C. J. Grossman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & SONS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 711
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: 4th Jan 1913 (Month) (Day) (Year)

7. AGE: 1 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Twin Falls Id

10. NAME OF FATHER Joe Jensen

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Jensen
(Address) Twin Falls Ida

15. Filed 1-5 1914 John W. Eagleton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 4 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913, to Jan 1914, that I last saw him alive on Jan 4 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Kidney trouble
Dansion

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. W. L. Alexander M. D.
1/5 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Id | DATE OF BURIAL: 1/5 1914

20. UNDERTAKER: C. Moench | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1085
Primary Registration District No.
(No. , St.)

File No. 712
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John William McDole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan (Month) 16 (Day) 1840 (Year)

7. AGE: 73 yrs. 11 mos. 20 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Conrad McDole

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Rebecca Bacarn

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J.W. McDole
(Address) Twin Falls

15. Filed 1-7 1914 John A. Bagley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2 1914, to Jan 6 1914, that I last saw him alive on Jan 6 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H.W. Wilson M. D.
Jan 6 1914 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Creston Iowa
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: T.J. Goodman
ADDRESS: Twin Falls Ida

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ____, ____ St.)

File No. 7121
Registered No. ____
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Doby Counar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Jan 22 (Month) (Day) 1914 (Year)

7. AGE: ____ yrs. ____ mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or 10 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry business, or dstablishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER John Counar

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Katherine Crowin

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Counar
(Address) Twin Falls

15.
Filed 1-22 1914 John H. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 22 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1914, to Jan 22 1914, that I last saw him alive on Jan 22 1914, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:
Injection from formation, bird
Few minutes
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ~~Dr~~
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. F. Fly M. D.
1/23/1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR ~~REMOVAL~~ | DATE OF BURIAL
Twin Falls | Jan 22 1914

20. UNDERTAKER C J Crosby | ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 7122
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louisa A. Baumann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)
6. DATE OF BIRTH: Feb. (Month) 5 (Day) 1877 (Year)
7. AGE: 36 yrs. 11 mos. 20 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: George Baumann
11. BIRTHPLACE OF FATHER (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Theresa Baumann
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Louisa A. Baumann
(Address) Albion Ida
15.
Filed 1-25 1914 John W. Eagleson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 25 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1914, to Jan 25 1914, that I last saw him alive on Jan 24 1914, and that death occurred on the date stated above, at 5.30 P.M.
The CAUSE OF DEATH* was as follows:
Tuberculosis Peritonitis
(Duration) yrs. mos. 10 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) [illegible] M. D.
Jan 25 1914 (Address) [illegible] Twin Falls,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion
DATE OF BURIAL: Jan 28 1913
20. UNDERTAKER: J. F. Goodman
ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 37
County of Twin Falls Primary Registration District No. 1085
City of " " (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Jacob B Watkins

File No. 7123
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: August 10th 1844 (Month) (Day) (Year)

7. AGE: 69 yrs. 5 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): United States, Ohio

10. NAME OF FATHER: Evan Watkins

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania U. S.

12. MAIDEN NAME OF MOTHER: Elizabeth Carter

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phil J. Langenour
(Address) Woodland, Cal.

15. Filed 2-1 1914 John P Coyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) - 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-10 1914, to 1-31 1914
that I last saw him alive on 1-31 1914
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Paralysis
.....
.....
..... (Duration) ..... yrs. ..... mos. 20 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
Feb 9 1914 (Address) [illegible] Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 2/3 1914
20. UNDERTAKER: [illegible] Freeman
ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 2085
County of Twin Falls
Primary Registration District No.
File No. 7121
City of ~~Twin Falls~~ (No. , St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Murrill Barry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: English
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Jan. (Month) 23 (Day) 1906 (Year)

7. AGE: 8 yrs. — mos. 3 ds.
IF LESS than 1 day how many .....*hrs.* or .....*mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ernest J. Barry

11. BIRTHPLACE OF FATHER (State or Country): North Car.

12. MAIDEN NAME OF MOTHER: Annie L. Frazelle

13. BIRTHPLACE OF MOTHER (State or Country): North Car.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie L Barry
(Address) Twin Falls

15. Filed 1-27 1914 John Eggleston Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1914, to Jan 26 1914
that I last saw h im alive on Jan 26 1914
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Sepsis -
Secondary to Alveolar Abscess
(Duration) yrs. mos. 10 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. R. Morgan M. D.
Jan. 26 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 1-28 1914

20. UNDERTAKER: Crosby — ADDRESS: Twin Falls

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [redacted]5725
Registered No. 3

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Binder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Oct - 5 - 1879
(Month) (Day) (Year)

7. AGE
34 yrs. 4 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R C Hamaday
(Address) Mtn Home, Idaho

15.
Filed Feb. 19th 1914 B L Mathes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. 18th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10th 1913, to Feb. 17th 1914, that I last saw him alive on Feb. 17th 1914, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. — ds.

Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B L Mathes M. D.
2/19 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home
DATE OF BURIAL: Feb 20 - 1914

20. UNDERTAKER: J M Cowen
ADDRESS: Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 125
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Midvale

Registration District No. 87
Primary Registration District No. 2154
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George Carpenter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ~~December~~ Feb 4 (Month) (Day) 1895 (Year)

7. AGE: 18 yrs. 1 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher of Latin
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Samuel Carpenter

11. BIRTHPLACE OF FATHER (State or Country): Linn Co Mo.

12. MAIDEN NAME OF MOTHER: Ada Baker

13. BIRTHPLACE OF MOTHER (State or Country): Mercer Co Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. L. Cotter
(Address) Midvale, Idaho

15. Filed Feb 21st 1914 Houston E Snyder Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1914, to Feb 20 1914
that I last saw h[illegible] alive on Feb 20 1914
and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:
Abcess of bowels appendicial
& tuberculus operation draining
acute heart failure after anaesthesia
..... (Duration) ..... yrs. 2 mos. - ds.
Contributory (Secondary) General debility
..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) W. T. Marshall M. D.
Feb 21 1914 (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale Cemetery
DATE OF BURIAL: Feb 22 1914

20. UNDERTAKER: [signature]
ADDRESS: Midvale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of E Westlake Precinct (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183

File No. 3 [illegible]
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella House,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 19 (Month) (Day) 1890 (Year)

7. AGE: 23 yrs. 10 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business, or establishment in which employed (or employer): Nothing Remunerative

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Joseph M. House

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mary Martha Dyer

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jefferson House.
(Address) Westlake, Ida.

15.
Filed Feby 9th 1914 W B Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 9th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Feb 7th 1914, ~~to~~ ~~191~~, that I last saw her alive on Feb 7th 1914, and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Epilepsy
(Duration) 8 yrs. — mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Russell Truitt M. D.
Feb 9 1914 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westlake Cemetary — DATE OF BURIAL: Feby 1914

20. UNDERTAKER: Jefferson House — ADDRESS: Westlake Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

File No. 4-M 7128
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma May Bledsoe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
Feb (Month) 3 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Cottonwood Ida

10. NAME OF FATHER J. H. Bledsoe

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Ida Williams

13. BIRTHPLACE OF MOTHER (State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Bledsoe
(Address) Cottonwood

15.
Filed Feb 10 1914 H Bolke
Deby Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
2 (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1914, to Feb 7 1914, that I last saw her alive on Feb 7 1914, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
meningitis (simple)

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Slimmick M. D.
Feb 8 1914 (Address) Cottonwood Idho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cottonwood — DATE OF BURIAL Feb 10 1914

20. UNDERTAKER Harry M West — ADDRESS Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5 129

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

County of Idaho

City of Cottonwood (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Willard Elbert Greene

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 20 (Day) 1913 (Year)

7. AGE: yrs. 7 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cottonwood

10. NAME OF FATHER: W O Greene

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Mollie Cottrell

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W O Greene

(Address) Cottonwood

15.

Filed Feby 23rd 1914 W B Beers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 22nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany. 16th 1914, to Feby. 22nd 1914, that I last saw him alive on Feb. 22nd, 1914, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 14 ds.

Contributory (Secondary) Pickets

(Duration) yrs. mos. ds.

(Signed) J. H. Turner M. D.

2/23/1914 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: Feb 24 1914

20. UNDERTAKER: Henry M West — ADDRESS: Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Broadford, (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 7077

File No. 7130
Registered No. 35

2. FULL NAME Barney M. McCann.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: October (Month) 1 (Day) 1889. (Year)

7. AGE: 24 yrs. 3 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ketchum, Ida.

10. NAME OF FATHER: Jno. McCann.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Mary McLaughlan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno McCann,
(Address) Broadford, Ida.

15.
Filed 7/10 1914 Robert H Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Epithelioma of the lip (cancer)
Not in attendance
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H Wright M. D.
7/7 1914 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue Ida | DATE OF BURIAL: 7/9 1914

20. UNDERTAKER: R. D. Harris | ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2022
File No. 7131
Registered No. 6

1. PLACE OF DEATH.
County of Blaine
City of Ketchum
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bridget Ford
If death occurred in a hospital, stitution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
Mar. (Month) 6th (Day) 1841 (Year)

7. AGE
72 yrs. 11 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Maryland.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. H. A. Harden
(Address) Ketchum

15.
Filed 7/16 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 14 (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1914, to Feb 14, 1914, that I last saw her alive on Feb 13, 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
Feb 14, 1914 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Idaho
DATE OF BURIAL: Feb 16, 1914

20. UNDERTAKER: Ralph S. Harris
ADDRESS: Hailey Ida

IVES-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Blaine

City of Hailey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. 2022

(No. ....., ... St.)

File No. 7132

Registered No. 7

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth G Chipman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): divorced

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 64 yrs. 2 mos. ~ ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ~

10. NAME OF FATHER: ~

11. BIRTHPLACE OF FATHER (State or Country): ~

12. MAIDEN NAME OF MOTHER: ~

13. BIRTHPLACE OF MOTHER (State or Country): ~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Sherry

(Address) Hailey Ida.

15. Filed 2/19 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 17th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1914 to Feb 17 1914, that I last saw h[illegible] alive on Feb 17 1914, and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed Kennicam M. D.

Feb 17 1914 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida. DATE OF BURIAL: Feb 18 1914

20. UNDERTAKER: Ralph S Harris ADDRESS: Hailey Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7133
Registered No. 21

1. PLACE OF DEATH.
County of Boise
City of Idaho City
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2 1 0
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Albert Trader

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Nov (Month) 28 (Day) 1873 (Year)

7. AGE: 70 yrs. 3 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Placer miner
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Trader
(Address) Idaho City

15.
Filed Mar 5 1914. May Fitz Deputy. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) - 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1914, to Feb 27 1914
that I last saw him alive on Feb 24 1914
and that death occurred on the date stated above, at 6.30 A.M.
The CAUSE OF DEATH* was as follows:
Nephritis, Chronic

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Fitz. M. D.
Mar 8 1914 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho City
DATE OF BURIAL: Mar 1 1914

20. UNDERTAKER: Had none
ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7134

Registered No. 20

1. PLACE OF DEATH.
County of Boise
City of Quartzburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2019

2. FULL NAME Antone Silver

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)
7. AGE: 89 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Portugal
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Thompson
(Address) Quartzburg Ida
15.
Filed Mar 8 1914 — May Fitz Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 15 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1914, to Feb 19 1914 that I last saw h[illegible] alive on Feb 13 1914 and that death occurred on the date stated above, at 10 M.
The CAUSE OF DEATH* was as follows:
La Grippe
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Fitz M. D.
Mar 8 1914 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Placerville Ida.
DATE OF BURIAL: Feb 17 1914
20. UNDERTAKER: Had none.
ADDRESS:

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai
City of Black Lake

Registration District No. 126
Primary Registration District No. 2204
(No. .... St.)

File No. 7136
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mina Kerr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
(Month) (Day) 1889 (Year)

7. AGE
25 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) England

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Antony Kerr
(Address) Black Lake Ida

15.
Filed March 9 1914
R S Jensen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1914, to ..... 191..., that I last saw her alive on Feb 17 1914 and that death occured on the date stated above, at 4 a.m. M.

The CAUSE OF DEATH* was as follows:
Heart failure following Childbirth
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Unger M. D.
Feb 19 1914 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....da
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cour d'Alene — DATE OF BURIAL: Feb 21 1914

20. UNDERTAKER: E. L. Wheeler — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

Registration District No. 126

Primary Registration District No. 2204

(No. ....., ... St.)

File No. 7137

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elbert Doherty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 14 (Day) 1899 (Year)

7. AGE: 14 Yrs. 3 Mos. 2 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas Doherty

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Mary Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Doherty
(Address) Chatcolet, Idaho

15. Filed Feb. 18— 1914

R. D. Jensen
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Accidental drowning in Chatcolet Lake, Idaho

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration .....Yrs.....mos.....ds.

(Signed) C. E. Clark M. D.

19.... (Address) Chatcolet Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison, Idaho — DATE OF BURIAL: Feb 18 1914

20. UNDERTAKER: E. W. Wheeler — ADDRESS: Harrison

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai
City of Chatcolet

Registration District No. 126
Primary Registration District No. 2204
(No. ..... St.)

File No. 113
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Custer Cooley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. March (Month) 19 (Day) 1904 (Year)

7. AGE 9 Yrs. 10 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At School
(b) General nature of industry, business, or establishment in which employed (or employer)... X

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph C. Cooley

11. BIRTHPLACE OF FATHER (State or Country) Ida.

12. MAIDEN NAME OF MOTHER Sophrone Lane.

13. BIRTHPLACE OF MOTHER (State or Country) Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph C. Cooley
(Address) Chatcolet Ida

15. Filed Feb 18 1914 R.S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Accidental drowning in
Chatcolet Lake

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Clark M. D.
19... (Address) Chatcolet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harrison	Feb 18 1914

20. UNDERTAKER	ADDRESS
E. W. Wheeler	Harrison

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 99
County of Bonneau Primary Registration District No. 2-177
City of St Anthony (No. ....., ... St.)
File No. 7130
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vernon Daniel Stuart

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Nov 26 1891
(Month) (Day) (Year)

7. AGE 22 yrs. 3 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rexburg Idaho

10. NAME OF FATHER James G. Stuart

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Hannah Walker

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James W. Stuart
(Address) St Anthony Ida.

15. Filed Nov 9 1914 W. A. Wilcox
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 3rd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ was attended to deceased 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
probably Uremic Coma
13 hrs
(Duration) ..... yrs. 1 mos. ..... ds.
Contributory Bright's disease
(Secondary) about
(Duration) 4 yrs. 4 mos. ..... ds.

(Signed) W. D. Wax M. D.
Nov 4 1914 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg Ida	Nov 6 1914

20. UNDERTAKER	ADDRESS
N. D. Yager	St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of
City of (No. , St.)

Registration District No. 103
Primary Registration District No. 2181

File No. 114
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Ball

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Don't Know

6. DATE OF BIRTH Unknown 191 (Month) (Day) (Year)

7. AGE 79 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: County Poor Farm
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Byers
(Address) County Farm, Grangeville

15.
Filed March 4 1914 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 18 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1914, to Feb 18 1914
that I last saw h[illegible] alive on Feb 18 1914
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
acute dilatation of Stomach

(Duration) few hours yrs. mos. ds.
Contributory (Secondary) Valvular lesion of heart
(Duration) Don't Know yrs. mos. ds.

(Signed) G. S. Stockton M. D.
Feb 19 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Feb 22 1914

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

File No. 7141

County of Idaho

City of Grangeville. Ida. (No. ....., ... St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter B Lawrence.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH: April (Month) 11 (Day) 1839 (Year)

7. AGE: 74 yrs. 9 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Retired Citizen

9. BIRTHPLACE (State or Country) Sangamon Co. Illinois

10. NAME OF FATHER John Lawrence

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Margaret Johnston

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary E. Wickman.
(Address) Grangeville Idaho

15.
Filed March 4 1914 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1914 to Feb 1 1914 that I last saw h[illegible] alive on ——— 191—, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Found dead in bed, from rupture obtained undoubtedly chronic valvular disease of heart
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. S. Stockton M. D.
Feb 2 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Prairie View,	Feb 3 1914

20. UNDERTAKER	ADDRESS
W E Graham	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Weston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ..... St.)

File No. 7142
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily Barnard Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: May (Month) 9 (Day) 1840 (Year)

7. AGE: 34 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Myron Barnard

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Rees

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Rose
(Address) Western Idaho

15.
Filed March 7 1914 A. Allen Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1914, to March 2 1914, that I last saw her alive on March 2 1914 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobaris

(Duration) 4 yrs. 2 mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr R W Smith M. D.
19 ..... (Address) Weston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weston
DATE OF BURIAL: 4 6 1914

20. UNDERTAKER: J. F. Newman
ADDRESS: Weston

A R Curtis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Clifton
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 143
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Zorata Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: May (Month) 4 (Day) 1900 (Year)

7. AGE: 2 yrs. 10 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Clifton Idho

10. NAME OF FATHER: Zoray Taylor

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Marler

13. BIRTHPLACE OF MOTHER (State or Country): Clifton Idho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis Taylor
(Address) Clifton Idaho

15.
Filed Feb. 12 1914 Allen R Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. J. Parkinson M. D.
19.... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Clifton — DATE OF BURIAL: Jan 17 1914

20. UNDERTAKER: A. J. Hagman — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

Primary Registration District No. 2119

File No. 114

County of Franklin

City of Weston (No. ....., ... St.)

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Bright

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Aug (Month) 28 (Day) 1900 (Year)

7. AGE: 13 yrs. 5 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Franklin

10. NAME OF FATHER: Gilbert Bright

11. BIRTHPLACE OF FATHER (State or Country): Wisc

12. MAIDEN NAME OF MOTHER: Christian

13. BIRTHPLACE OF MOTHER (State or Country): Wisc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gilbert Bright
(Address) Preston R F D 2

15.
Filed Feb 14 1914 D. Allen R Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 6 1914, to Febr 15 1914, that I last saw h[illegible] alive on Febr 14 1914 and that death occurred on the date stated above, [illegible] M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) No yrs. 2 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W States M. D.
Febr 16 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [illegible] | DATE OF BURIAL: [illegible] 1914

20. UNDERTAKER: J H Brown | ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 7146
Registered No. 15

1. PLACE OF DEATH.
County of Franklin
City of Oxford (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Clements

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: May (Month) 26 (Day) 1846 (Year)

7. AGE: 69 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Clements

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Jorgesen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M McCoy
(Address) Clifton Ida.

15.
Filed March 7 1917 W. Allen Preston Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 27 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21 1917 to Feb 27 1917 that I last saw ~~him~~ alive on Feb 27 1917 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Acute Rheumatism
with endocarditis

(Duration) 6 yrs. 1 mos. 6 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R W Davis M. D.
2/25 1917 (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oxford Ida
DATE OF BURIAL: March 10 1917

20. UNDERTAKER: O J Hansen
ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Iona (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

File No. 7147
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles N. Rockwood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 2 (Day) 1850 (Year)

7. AGE: 64 yrs. 1 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Albert P. Rockwood

11. BIRTHPLACE OF FATHER (State or Country): Boston Mass

12. MAIDEN NAME OF MOTHER: Peepler

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Rockwood - Bro
(Address) Iona, Ida

15. Filed Dec 6 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl. 1913, to Mar 1914, that I last saw him alive on Mar 2 1914, and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

(Duration) 1 yrs. 4 mos. — ds.

Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.

(Signed) J. M. Bridges M. D.
19.... (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Salt Lake City, Utah | DATE OF BURIAL .....191...

20. UNDERTAKER: C. E. Dinwoodey | ADDRESS: Ida Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
~~City of~~ Ammon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 21
(No. ....., ... St.)

File No. 7149
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geneva Dorothy Ricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
~~Female~~	White	Child

6. DATE OF BIRTH
Janry (Month) 2 (Day) 1906 (Year)

7. AGE
8 yrs. 1 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Child
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ammon, Idaho

10. NAME OF FATHER Ernest Ricks

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary G. Molen

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Ricks - C&S
(Address) RD 3 Idaho Falls

15.
Filed Mar 1 1914
C. Simmons
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feby (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1913, to Feb 28 1914, that I last saw h~~e~~r alive on ~~On~~ Feb 27 1914, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
.....
.....
(Duration) One yrs. 3 mos. 10 ds.
Contributory Rheumatism
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Thuke M. D.
19 (Address) Boyer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL ~~OR REMOVAL~~ | DATE OF BURIAL
Ammon, Ida | 3/7 1914

20. ~~UNDERTAKER~~ | ADDRESS
C. E. Dimmoodey | Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 2137
(No. ..... , ... St.)

File No. 715
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leonard Hatton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Sept (Month) 24 (Day) 1853 (Year)

7. AGE: 59 yrs. 4 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: James Hatton

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Rachel Thomaker

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Milleard Linneman
(Address) Idaho Falls

15. Filed Feb 28 191[illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1913, to Feb 26 1914, that I last saw h[illegible] alive on Feb 26 1914, and that death occurred on the date stated above, at 3.35 P.M.

The CAUSE OF DEATH* was as follows:
Gastric Ulcer
Followed with
Pentonitis - Fatal Days.
(Duration) 1 yrs. 6 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John O Miller M. D.
19[illegible] (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Koposo Indiana | DATE OF BURIAL: Shipped 191[illegible]

20. UNDERTAKER: G H Hunt | ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls (No. 709, "G" St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 2
File No. 151
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Morris Obrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1913 (Year)

7. AGE: x yrs. 5 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Obrey

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Eliz. Bruce

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Obrey
(Address) Idaho Falls

15. Filed 2/23 191 4 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 - 22 - 14 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-19-14 191, to 2-22-14 191, that I last saw h[illegible] alive on 2-22-14 191, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Simple Meningitis

(Duration) yrs. mos. 4 ds.

Contributory (Secondary) None

(Duration) - yrs. - mos. - ds.

(Signed) F. M. Bridges. M. D.

19 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE ~~OF BURIAL~~ OR REMOVAL: Montpelier Ida
DATE OF BURIAL: 7/24 191[illegible]

20. UNDERTAKER: C. E. Dinwoodey
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1
(No. 9" —, St.)

File No. 7152
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah E. Burt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
March (Month) 8 (Day) 1892 (Year)

7. AGE
21 yrs. 11 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER Chas Moore

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Nixon

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Burt
(Address) [illegible]

15. Filed 2/17 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feby (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15th 1914, to Feb. 15th 1914; that I last saw her alive on Feb 15th 1914, and that death occurred on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:
Air Embolus following Confinement

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. C. Hollister, M. D.
2-16- 1914 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Idaho Falls	2/17 1914

20. UNDERTAKER	ADDRESS
C. C. Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 715
Registered No. 1

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 7
(No. ..., D" St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Babe) [redacted] Burt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH: Feby (Month) 15 (Day) 1914 (Year)

7. AGE: x yrs. x mos. x ds. IF LESS than 1 day how many ..... hrs. or 20 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: ~~Henry~~ Robert Burt

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: Sarah Moore

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Burt - Father
(Address) Ido Falls

15.
Filed [illegible] 191[illegible] [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1914, to Feb 15 1914, that I last saw h[illegible] alive on [illegible] 191[illegible], and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Dr Hyer Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) Pleuro Pneumonia

(Duration) 2 yrs. ... mos. ... ds.

(Signed) J. C. Hollister M. D.

[illegible] 191[illegible] (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL, ~~OR REMOVAL~~	DATE OF BURIAL
Idaho Falls	2/15 1914
20. UNDERTAKER	**ADDRESS**
C. E. Dimmoodey	Ido Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 715+
Registered No. 11

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. ...
Primary Registration District No. ...

2. FULL NAME Edward Ferguson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Feb (Month) 12 (Day) 1907 (Year)

7. AGE: 7 yrs. 3 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. A Ferguson

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Knetting

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A Ferguson
(Address) Idaho Falls

15. Filed Feb 16 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9 1914, to Feb 14 1914, that I last saw h~~im~~ alive on Feb 14 1914 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Appendicitis Peritonitis
Operation

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) C. M. Glenn M. D.
2/16 1914 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelton Idaho	2/16 1914
20. UNDERTAKER	**ADDRESS**
C. N. Hunt	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2100
(No. ....., ... St.)

File No. 7156
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Baby) Charles L Erickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH: Feby (Month) 8 (Day) 1914 (Year)

7. AGE: x yrs. x mos. x ds. IF LESS than 1 day how many ....hrs. or ....mins.? 1

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles L. Erickson

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Anna May Higbee

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Erickson Fa
(Address) Idaho Falls

15. Filed Feb 10 1914 Corey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191...,
that I last saw h[illegible] alive on Feb. 8 1914
and that death occurred on the date stated above, at 1730 M.
The CAUSE OF DEATH* was as follows: Premature Birth 7 Mo.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. R. Dodgenmash M. D.
2/10 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 2/11 1914

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ido. Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No.
(No. Gen. Hospital St.)

File No. 115
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph S. Willis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Feby (Month) 25 (Day) 1876 (Year)

7. AGE
37 yrs. 11 mos. 10 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Drayman
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Thomas J. Willis

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Ann L Pratt

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ralph Willis
(Address) Idaho Falls. Ida.

15.
Filed Feb 7 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feby. (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2 1914, to Feb. 5, 1914; that I last saw him alive on Feb. 4, 1914, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Cardiac dilatation

(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) John O'Kelly M. D.
2/7 1914 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Idaho Falls Ida — DATE OF BURIAL 2/8 1914

20. UNDERTAKER C E Dunwoody — ADDRESS Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & PORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Shelton:
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 72
Primary Registration District No. 2 1 6 3
(No. ....., ... St.)

File No. 7150
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Maud Brown.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Aug (Month) 27 (Day) 1877 (Year)

7. AGE
36 yrs. 4 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Hyrum Page

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Emma J. Tingey

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake. Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Brown
(Address) Ryby R.D. 2

15.
Filed Jan. 10. 1914 C. W. Chamberlain Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1913, to Jan 2nd 1914, that I last saw her alive on Jan 2nd 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Eclampsia.
Fatal toxemia of Pregnancy.
(Duration) ..... yrs. 2 mos. probably ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. W. Gibbons M. D.
Jan 5 1914 (Address) Ryby, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelton Cemetery — DATE OF BURIAL: Jan 6th 1914

20. UNDERTAKER: S. H. Hunt — ADDRESS: Ida. Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

6

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 56
Primary Registration District No. 2112
(No. ....., ... St.)

File No. 7161
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Dovis

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
Nov (Month) 24 (Day) 1892 (Year)

7. AGE
21 yrs. 3 mos. 2 ds.
IF LESS than 1 day old, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Provo Utah

10. NAME OF FATHER R. T. Dovis

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Hallie Smith

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. T. Dovis
(Address) Weiser

15.
Filed March 1st 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February (Month) 25th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6th 1913, to Feb 25th 1914
that I last saw h[illegible] alive on February 26th 1914
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Portal Embolism

(Duration) ..... yrs. 10 mos. — ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. R. Hamilton M. D.
3/2 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days.
In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida
DATE OF BURIAL: March 2 1914

20. UNDERTAKER: L. L. Northam
ADDRESS: Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4162

Registered No. 5

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 76

County of Washington Primary Registration District No. 2112

City of Weiser (No. 20 miles up Mann Ck. from Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Virginia Gent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: March (Month) – 23 (Day) 1831 (Year)

7. AGE: 82 yrs. 11 mos. 1 ds. IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of Virginia

10. NAME OF FATHER: Harvey Ward

11. BIRTHPLACE OF FATHER (State or Country): State of Virginia

12. MAIDEN NAME OF MOTHER: Lina Payne

13. BIRTHPLACE OF MOTHER (State or Country): State of Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. M. Higginbotham
(Address) Weiser, Idaho R.F.D

15. Filed Feb 26 1914 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) – 24 (Day) – 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 20 1914, to February 24 1914 that I last saw her alive on February 24 1914 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) .....yrs.....mos.....ds.

Contributory (Secondary)

..... (Duration) .....yrs.....mos.....ds.

(Signed) Jules A Young M. D.

Feb 26 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elgin, Oregon — DATE OF BURIAL: Feb-28 1914

20. UNDERTAKER: R. W. Bowen — ADDRESS: Weiser Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. .....

Name Mrs. Virginia Cent

Date of Death Feb. 24. 1914.

Cause of Death Bronchial Pneumonia

Contributary Cause of death old age

(Sign here) James O Young M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7163

Registered No. 6

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Washington
City of Weiser
Registration District No. 86
Primary Registration District No. 1010
(No. East Commercial St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Elizabeth R. Neff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Feb — 13 — 1846 (Month) (Day) (Year)
7. AGE: 68 yrs. — mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): State of Missouri
10. NAME OF FATHER: Giles Sater
11. BIRTHPLACE OF FATHER (State or Country): State of N. Carolina
12. MAIDEN NAME OF MOTHER: Mary Dardin
13. BIRTHPLACE OF MOTHER (State or Country): State of Illinois
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Neff
(Address) Weiser Ida.
15. Filed Feb 22nd 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. — 21 — 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 7 1914, to Feb 21st 1914 that I last saw her alive on Feb 21st — 1914 and that death occurred on the date stated above, at 1:35 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis

(Duration) Years yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. R. Hamilton M. D.
Feb. 22nd 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: Feb. 23 1914

20. UNDERTAKER: R. W. Brown — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 2112
(No. ....., ... St.)

File No. 7164
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorenzo D. Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Apr (Month) 26. (Day) 1855 (Year)

7. AGE
58 yrs. 2 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rosella Hamilton
(Address) Payette Idaho

15.
Filed Jan 21st 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Killed by train on
O. S. L. R. R. accidentally

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James T McCann M. D. Coroner
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida
DATE OF BURIAL: 1/21 1914

20. UNDERTAKER: L. C. Northam
ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 56
County of Washington Primary Registration District No. 2112
City of Weiser (No. ....., ... St.)
File No. 7165
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Elizabeth Coat

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb — 17 — (or) 1837 (Month) (Day) (Year)

7. AGE: 77 yrs. 10 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Newton Co. Missouri

10. NAME OF FATHER: John Hackbee

11. BIRTHPLACE OF FATHER (State or Country): State of Tenn.

12. MAIDEN NAME OF MOTHER: Elizabeth —

13. BIRTHPLACE OF MOTHER (State or Country): State of Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susan Carmical
(Address) Weiser Idaho.

15. Filed Jan 13th 1914 W R Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan — 12 — 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1913, to Jan 12 1914, that I last saw her alive on Dec 27 1913 and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
..... (Duration) Don't Know yrs. ..... mos. ..... ds.
Contributory Pneumonia
(Secondary)
..... (Duration) Don't Know yrs. ..... mos. ..... ds.
(Signed) Houston & Lyndon M. D.
Jan 12 1914 (Address) Midvale Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Manna Crk. Weiser Ida — DATE OF BURIAL: Jan 13 1914

20. UNDERTAKER: R. W. Bowers — ADDRESS: Weiser Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 116

Registered No. 3

1. PLACE OF DEATH. Registration District No. 56

County of Washington Primary Registration District No. 1110

City of Weiser (No. 1100, 4th St West St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Wood

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: October (Month) 23 (Day) 1842 (Year)

7. AGE: 71 yrs. 2 mos. 20 ds.

IF LESS than 1 day how many .....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Independence Ohio

10. NAME OF FATHER: Benjamin Wood

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Charlotte Bull

13. BIRTHPLACE OF MOTHER (State or Country): State of Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): [illegible]
(Address): Weiser, Ida.

15. Filed Jan 14 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8th 1914, to Jan 12, 1914 that I last saw him alive on Jan 10 1914 and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Pleurisy, Mitral regurgitation.

(Duration) 8 yrs. 7 mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. E. Gemmell M. D.

Jan 14 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cleveland Ohio — DATE OF BURIAL: Jan 21 1914

20. UNDERTAKER: A. G. Crabb — ADDRESS: Weiser Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

22

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 56.
Primary Registration District No. 1010
(No. Cor; 7th & E. Court St.)

File No. 7162
Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Virgil Purbaugh.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Nov 8 1913
(Month) (Day) (Year)

7. AGE
— yrs. 2 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Weiser Ida

10. NAME OF FATHER C E Purbaugh.

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Lillie Lawley

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Purbaugh
(Address) Weiser Ida

15.
Filed Jan 14th 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January 12th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12th 1914, to Jany 12th 1914, that I last saw him alive on Jan 12th 1914, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Convulsions

(Duration) ..... yrs. ..... mos. 2 hrs.,
Contributory (Secondary) Cerebral Anaemia
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W. R. Hamilton M. D.
Jan 14 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weiser Ida	Jan 14 1914

20. UNDERTAKER	ADDRESS
L. L. Martin	Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7168
Registered No. 1

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 1010
City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ina Violet Washburn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: November – 8 – 1879 (Month) (Day) (Year)
7. AGE: 35 yrs. 1 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ashland, Oregon
10. NAME OF FATHER: Martin McCall
11. BIRTHPLACE OF FATHER (State or Country): State of New York
12. MAIDEN NAME OF MOTHER: Lena Applegate
13. BIRTHPLACE OF MOTHER (State or Country): Utah of Oregon
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. C. Washburn
(Address) Council, Idaho.
15. Filed Jan 6th 1914 W. R. Brumbaugh Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan – 5 – 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1913, to Jan 5 – 1914 that I last saw h[er] alive on Jan 5 1914 and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:
Cardiac Embolism Thrombosis
..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Pafaudism
..... (Duration) ..... yrs. ..... mos. 4 ds.
(Signed) E. B. Dudley M. D.
..... 19..... (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashland Oregon Council Idaho — DATE OF BURIAL: Jan 6 – 1914
20. UNDERTAKER: R. G. Cordelle — ADDRESS: Weiser, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7169
Registered No.

1. PLACE OF DEATH.
County of Boise
City of Arrowrock
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 231
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Royal Warner Getts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (*Write* the word.)

6. DATE OF BIRTH: December 21 1874 (Month) (Day) (Year)

7. AGE: 39 yrs. 0 mos. 15 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Construction Foreman.
(b) General nature of industry business or establishment in which employed (or employer): In charge of placing material in dam foundation.

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Geo. M. Getts,

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Electa McIntyre

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Lou L Braslid
(Address) 911 E. Wash Boise

15.
Filed Jan. 5 1914 James P Kerby M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17 1913, to Jan. 5 1914 that I last saw h[im] alive on Jan. 5 1914, and that death occurred on the date stated above, at 5.45 a. M.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull received while at work on Arrowrock Dam, by falling timber (Duration) — yrs. — mos. 19 ds.

Contributory (Secondary) Cerebral thrombo-phlebitis (Duration) — yrs. 1 mos. 1 ds.

(Signed) James P Kerby M. D.
Jan. 5 1914 (Address) Physician, U.S.R.S. Arrowrock, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ... mos. 20 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Arrowrock
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Ida. DATE OF BURIAL: 1/7 1914

20. UNDERTAKER: W. C. Myer ADDRESS: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kamiah, Idaho

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

File No. 411
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Hollingshead

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married
6. DATE OF BIRTH: March (Month) 7th (Day) 1841 (Year)
7. AGE: 72 yrs. 11 mos. 23 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: Willaim Hazelwood
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Mary Hazelwood
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W A Hollingshead
(Address) Kamiah, Idaho
15.
Filed May 8th 1914 W. J. M[illegible] M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 28 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191....
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(there were two light strokes previously
Died in toilet without medical attention)
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Willow Hill Cemetery
DATE OF BURIAL: Mar 2 1914
20. UNDERTAKER: C J Johnson
ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 174
Registered No.

1. PLACE OF DEATH.
County of LATAH
City of
(No. , St.)
Registration District No.
Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Erwin Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: Sept 12 1868 (Month) (Day) (Year)

7. AGE: 45 yrs. 5 mos. ~ ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ills.

10. NAME OF FATHER: Andrew Nelson.

11. BIRTHPLACE OF FATHER (State or Country): United States.

12. MAIDEN NAME OF MOTHER: Mary Foss

13. BIRTHPLACE OF MOTHER (State or Country): United States.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E Nelson
(Address) Walla Walla Wash.

15. Filed Feby 13 1914 S. A. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby 12 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 10 1914, to Feby 12 1914 that I last saw him alive on Feby 12 1914 and that death occurred on the date stated above, at 3³⁰ P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) S. A. Roe, M. D.
Feby 13 1914. (Address) Juliaetta Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Brandon S. D.
DATE OF ~~BURIAL~~ Shipment: Feby 13 1914

20. UNDERTAKER: J. C. Roseclose
ADDRESS: Juliaetta Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1150

Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Wendell
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22
Primary Registration District No. 2014

2. FULL NAME Emaline Johnston Taylor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Dec. 24 1842 (Month) (Day) (Year)

7. AGE: 71 yrs. 1 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Wm. Johnston

11. BIRTHPLACE OF FATHER (State or Country) New Jersey

12. MAIDEN NAME OF MOTHER Hannah Schuler

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leah Taylor Cornelison
(Address) Wendell Idaho

15.
Filed Mar 1 1914 W. P. Lamb
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to Feby 22 1914
that I last saw h[illegible] alive on Feb 22 1914,
and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Duration) 0 yrs. 9 mos. 0 ds.
Contributory (Secondary) Thyro-Toxicosis
(Duration) 1 yrs. 8 mos. ds.

(Signed) J. F. Cornelison M. D.
Feb. 23 1914 (Address) Wendell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Idaho
DATE OF BURIAL: Feb. 25 1914

20. UNDERTAKER: None
ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. CANYON
County of
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 7
File No. 117
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Maurice La Lande.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH: May (Month), 12th (Day), 1841 (Year)

7. AGE: 72 yrs. 9 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Retired farmer.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: P. X. La Lande.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: O. Bartrent.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maurice La Lande Jr.
(Address) Nampa, Ida.

15. Filed Mch 9 1914 S. D. Calonge
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month), 8th (Day), 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/20/1914, to 3/8/1914 that I last saw h. alive on the 8th of Mar, 1914, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.

(Duration) — yrs. — mos. — ds.
Contributory (Secondary): Mitral regurgitation & asthma
(Duration) 20 yrs. — mos. — ds.

(Signed) Geo. C. A. Kellogg M. D.
3/9/1914 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem. DATE OF BURIAL: Feb 10 1914

20. UNDERTAKER: D. B. Shellabarger ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 7
(No. , St.)

File No. 717
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME David Hilty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: January (Month) 30 (Day) 1845 (Year)

7. AGE: 69 yrs. 1 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer and
(b) General nature of industry business, or establishment in which employed (or employer): Minister

9. BIRTHPLACE (State or Country): Pandora - Putnam Co. Ohio.

10. NAME OF FATHER: John Hilty

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Katherya Niewander

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. A. Hilty
(Address) Nampa Ida

15.
Filed Mch 9 1914 D. D. Calaway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191 , to Mch 7 1914
that I ~~last~~ saw him alive on Mch 7 1914
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) yrs. mos. ds.
Contributory (Secondary) Arterial Sclerosis
(Duration) ? yrs. ? mos. ? ds.

(Signed) D. D. Calaway M. D.
Mch 9 1914 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Yohler Lawn
DATE OF BURIAL: Mch 11 1914

20. UNDERTAKER: F. K. Robertson
ADDRESS: Nampa

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 7
(No. , St.)

File No. 717
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary E McHam

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: 1830 (Month) Dec (Day) 15 (Year)

7. AGE: 83 yrs. 2 mos. 16 ds. IF LESS than 1 day how many 22 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Henry Conley

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Nancy Brown

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Gooding
(Address) Nampa Idaho

15. Filed Mch 5 1914 S D Calonge Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 4 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 3 1914, to Mch 4 1914, that I last saw her alive on Mch 3 1914, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Pneumonia (double lobar)
(Duration) Hours Yrs. Mos. Days ds.
Contributory (Secondary) Age and general debility
(Duration) yrs. mos. ds.
(Signed) S D Calonge M. D.
Mch 4 1914 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos ds. In the State yrs mos ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Boise Valley Cem
DATE OF BURIAL: Mch 6 1914

20. UNDERTAKER: No.
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.

County of Primary Registration District No. 7 File No. 1170

City of (No. , St.) Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Febr. (Month) 28th. (Day) 1914 (Year)

7. AGE: ___ yrs. ___ mos. ___ ds. IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nampa. Ida.

10. NAME OF FATHER: Sam Migaki

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Naka Kuridara

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Migaki
(Address) Reg. Geo. A. A. Kellogg. Nampa Ida.

15. Filed Feb 28 1914 D.S. Calenger Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr. (Month) 28th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 P.M. 2/28/1914, to 5-45 P.M. 2/28/1914, that I last saw her alive on Feb. 28, 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth.

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (Secondary)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Geo. A. A. Kellogg M. D.
2/28/1914 (Address) Nampa. Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Kohler Lawn — DATE OF BURIAL: March 1st 1914

20. UNDERTAKER: No — ADDRESS:

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

File No. 718

County of Nez Perce

City of Lewiston (No. South approach R. Ry Bridge)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unknown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W.	Single

6. DATE OF BIRTH

Unknown 1
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. Vassar

(Address) Lewiston

15.

Filed 3-10-1914 S. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Found 2 3 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,

that I last saw h— alive on — 191...,

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

— Premature —

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) D. Vassar Coroner

19... (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	3-4 1914

20. UNDERTAKER	ADDRESS
D. Vassar	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of [redacted]
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. 1507, 6 St.)

File No. 718
Registered No. 8
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth E. Smithurn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	[illegible]

6. DATE OF BIRTH: Jan (Month) 31 (Day) 190- (Year)

7. AGE: 13 yrs. — mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: schoolgirl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho P.O. Nezperce

10. NAME OF FATHER: John Smithurn

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lidga Hauboer

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Hasson
(Address) Lewiston

15. Filed 3-10- 1914 S. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from once 1914, to Feb 4" 1914
that I last saw h[illegible] alive on Feb 4" 1914,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Chronic pericarditis

(Duration) 10 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. R. Moulton M. D.
2/9 19 (Address) Main St Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 8 1914

20. UNDERTAKER: J. Hasson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7182
Registered No. 9

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 9c
Primary Registration District No. 1009
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Jerome Pedigo.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: May (Month) 19 (Day) 1839 (Year)

7. AGE: 74 yrs. 9 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Elvin Pedigo

11. BIRTHPLACE OF FATHER (State or Country): X X

12. MAIDEN NAME OF MOTHER: X X Gill

13. BIRTHPLACE OF MOTHER (State or Country): X X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Pedigo
(Address) Clarkston Wash

15. Filed 3-10-1914 L J Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12- 1914, to Feb. 12- 1914 that I last saw h[illegible] alive on Feb. 12 1914 and that death occurred on the date stated above, at 7. P. M.

The CAUSE OF DEATH* was as follows:
Arterio sclerosis.
(Duration) Died out of town ds.
Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Perkins M. D.
Feb. 13 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wn
DATE OF BURIAL: Feb 14 1914

20. UNDERTAKER: H R Merchant
ADDRESS: Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 718
Registered No. 78

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME H. A. Boynton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	Single

6. DATE OF BIRTH: Nov 1 (Month) 1 (Day) 1851 (Year)

7. AGE: 61 yrs. 3 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bridge Foreman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario

10. NAME OF FATHER: W. P. Boynton

11. BIRTHPLACE OF FATHER (State or Country): Ontario

12. MAIDEN NAME OF MOTHER: A. W. Troulton

13. BIRTHPLACE OF MOTHER (State or Country): Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. B. Coates
(Address) Lewiston Ida

15. Filed 3-10- 1914 S. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb January 19th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20th 1914, to Feb 12th 1914, that I last saw him alive on Feb 11th 1914 and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Pericardial Adhesion

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Rowen M. D.
19 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: San Francisco | DATE OF BURIAL: Feb 1914

20. UNDERTAKER: H. Warren | ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 718

Registered No. 11

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. ..., Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob L. Bubal.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb 2 1 (Month) (Day) (Year)

7. AGE: 18 yrs. ... mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ...
(b) General nature of industry business, or dstablishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): South Dakota

10. NAME OF FATHER: Lark

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Louise Doser

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. Vasser
(Address): Lewiston

15. Filed 3-10- 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 17 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1914, to Feb 16 1914, that I last saw h.. alive on Feb 16 1914 and that death occurred on the date stated above, at 12-M.

The CAUSE OF DEATH* was as follows:

Diabetes.

(Duration) 1 yrs. ... mos. ... ds.

Contributory (Secondary) Diabetes Mel

(Duration) 1 yrs. ... mos. ... ds.

(Signed) Edgar L. White M. D.

Feb 17 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 1 days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death? Nez Perce Ida

Former or usual residence Nez Perce Ida

19. PLACE OF BURIAL OR REMOVAL: Nez Perce Ida — DATE OF BURIAL: Feb 1914

20. UNDERTAKER: J. Vasser — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 718
Registered No. 12

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. 1327, 10th Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Cook,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	Married

6. DATE OF BIRTH: July (Month) 2 (Day) 1826 (Year)

7. AGE: 86 yrs. 7 mos. 20 ds. IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miller
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holland

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Cook
(Address) Lewiston Ida.

15. Filed 3-10- 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 22nd (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4th 191..., to Feb 22nd 1914, that I last saw him alive on Feb 4th 1914, and that death occurred on the date stated above, at 5-25 P.M.

The CAUSE OF DEATH* was as follows:

Gradual decline from old age

(Duration) ...yrs. ...mos. ...ds.

Contributory (Secondary)

(Duration) ...yrs. 7 mos. ...ds.

(Signed) J. H. Course M.D.

1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	Feb 28 1914

20. UNDERTAKER	ADDRESS
Lewiston	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Idaho.

~~WASHINGTON~~ STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 718

File No.

Registered No. 13

PLACE OF DEATH

County of Nez Perce

City or Town of Lewiston

Registration Dist. No.

(No. 122 5th St. St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]

Full Name John Fremont Hulbut

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V.S. No. 1

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept 29 (Month) (Day), 1861 (Year)

7 AGE: 52 yrs. 4 mos. 24 ds. If LESS than 1 day, hrs. or mln.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Wisconsin

PARENTS

10 NAME OF FATHER: Harold H. Hulbut

11 BIRTHPLACE OF FATHER (State or country): New York

12 MAIDEN NAME OF MOTHER: Minnie Kniss

13 BIRTHPLACE OF MOTHER (State or country): Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs J. F. Hulbut
(Address): Lewiston, Idaho

15 Filed 3-10-, 1914 L. J. Rentschler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 22 (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1914, to Feb 22, 1914, that I last saw h alive on Feb 22, 1914, and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH * was as follows:
Chronic interstitial nephritis

about (Duration) 2 yrs. mos. ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) David H. Rappaport, M. D.
Feb 23 1914 (Address) Clarkston, Wn.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lewiston, Ida.

DATE OF BURIAL: Feb 24 1914

20 UNDERTAKER: C. J. Vassar

ADDRESS: Lewiston, Id.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 718

Registered No. 15

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. ....., Hospital St.)

Registration District No. 9c

Primary Registration District No. 1009

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James W Snodgrass

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 3rd, 24 (Day) 1890 (Year)

7. AGE: 23 yrs. 8 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster,
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: M. Snodgrass

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Ida West.

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Snodgrass
(Address): Orofino

15. Filed 3-10- 1914 C. M. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1914, to Feb 26 1914, that I last saw h in alive on Feb 26 1914 and that death occurred on the date stated above, at 5 9 M.

The CAUSE OF DEATH* was as follows:

Gun Shot wound in abdomen.

(Duration) ..... yrs. ..... mos. 9 hours ds.

Contributory (Secondary) Hemorrhage of Liver & Spleen.

(Duration) ..... yrs. ..... mos. 9 hrs ds.

(Signed) Elmer G. Braddock M. D.

Feb 26 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho — DATE OF BURIAL: 2-28 1914

20. UNDERTAKER: J. Hassar — ADDRESS: Lewiston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 718
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ed. Hayden

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH [illegible] (Month) [illegible] (Day) 1856. 1914 (Year)

7. AGE 58 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) New Hampshire

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno W Graves
(Address) Orofino Ida

15. Filed Jan 1 191[illegible] J M Fairly Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. (Month) 17. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1913, to Jan 17 1914 that I last saw him alive on Jan 16 1914 and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Insanity
..... (Duration) 16 yrs. ..... mos. ..... ds.
(Signed) John W. Graves M. D.
Jan 17. 1914 (Address) Orofino. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino, Ida	Jan 19 1914

20. UNDERTAKER	ADDRESS
[illegible] Rayburn	[illegible] Orofino, Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7197
Registered No. 124

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Cavendish (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Perry C Daniels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Wht	Married

6. DATE OF BIRTH January 13 1890
(Month) (Day) (Year)

7. AGE 24 yrs. ..... mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) W. Virginia

10. NAME OF FATHER J. H. Daniels

11. BIRTHPLACE OF FATHER (State or Country) W Virginia

12. MAIDEN NAME OF MOTHER Martha Stalnaker

13. BIRTHPLACE OF MOTHER (State or Country) W Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D H Daniels
(Address) Cavendish Idaho

15. Filed Feby 10 1914 J M Darby
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feby 9 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 2 1914, to Feby 9 1914
that I last saw h im alive on Feby 9 1914
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C C Bussey M. D.
Feby 10 1914 (Address) Cavendish Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Southwick	Feby 12 1914

20. UNDERTAKER H E Stoddard
ADDRESS Clifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 160

Primary Registration District No. 278

File No. 191

Registered No. 13

County of Madison

City of Sugar (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen L. Fullmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 1 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sugar

10. NAME OF FATHER: John C. Fullmer Jr

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Augusta E. Teyles

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John C. Fullmer Jr
(Address): Sugar

15. Filed 2-12 1914 G. G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 6th. (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5th 1914, to Feb 6th 1914, that I last saw h[illegible] alive on Feb 5th 1914, and that death occurred on the date stated above, at 6.30 M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Shupe M. D.

19 (Address) Sugar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ryburg — DATE OF BURIAL: 2/7 1914

20. UNDERTAKER: [illegible] — ADDRESS: Ryburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 7192

Registered No. 14

County of Madison

City of Rexburg (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Skelton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH

Aug. (Month) 22 (Day) 1825 (Year)

7. AGE

88 yrs. 5 mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nova Scotia

10. NAME OF FATHER Wm Glover

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Catherine Owens

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs R. D. Hunt

(Address) Rexburg

15.

Filed 2-9 1914 G. G. Esper Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1914, to Feb. 7, 1914, that I last saw h[illegible] alive on Feb 5 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) Senility Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. Thurmon M. D.

Feb 9 1914 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	2/11 1914

20. UNDERTAKER	ADDRESS
John Phillips	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7192

Name Jane Skelton

Date of Death Feb. 7, 1914

Cause of Death Acute Bronchitis

Contributary Cause of death Chronic nephritis

(Sign here) A. C. Emerson M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 193
Registered No. 15

1. PLACE OF DEATH.
County of Madison
City of Sugar (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mayzel Price Rigby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: April (Month) 7 (Day) 1907 (Year)

7. AGE: 6 yrs. 10 mos. 7 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Driggs Fremont Co. Ida.

10. NAME OF FATHER: David E. Rigby

11. BIRTHPLACE OF FATHER (State or Country): Newton Cache Co. Utah

12. MAIDEN NAME OF MOTHER: Agnes Elsie Price

13. BIRTHPLACE OF MOTHER (State or Country): Nephi Juab Co. Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David E. Rigby
(Address) Sugar

15. Filed 2-19 1914. G. L. Estes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1914, to Feb 19 1914, that I last saw h[illegible] alive on Feb 14 1914, and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:
Acute Heart Failure
Recovery Rheumatism

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Rheumatism
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Snyder M. D.
19 (Address) Silver City,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar | DATE OF BURIAL: 2/16 1914

20. UNDERTAKER: [illegible] | ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 7194

Registered No. 16

County of Madison

City of Rexburg (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hatsuse Sasaki

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Japanese	

6. DATE OF BIRTH: Jan (Month) 8 (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER K Sasaki

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Shio Ando

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. Kanamu

(Address) .....

15. Filed 2-17 1914 R. L. Kespe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	2-18 1914

20. UNDERTAKER	ADDRESS
John Phillips	Rex

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 719
Registered No. 17

1. PLACE OF DEATH.
County of Madison
City of Rexburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kennett C. Paul

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Feb. (Month) 20, (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ~~3 Days~~ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rexburg, Madison Co. Idaho.

10. NAME OF FATHER Oscar L. Paul

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Emily Randall

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Paul
(Address) .....

15. Filed 2-23 1914 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 20, (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20 1914, to Feb. 20, 1914 that I last saw h~~im~~ alive on Feb. 20 1914, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ..... yrs. ..... mos. 3 Hrs. ds.

Contributory (Secondary) Birth Pressure

(Duration) ..... yrs. ..... mos. 6 hr. ds.

(Signed) H. A. Crismon M. D.

Feb. 20, 1914 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	2-21 1914
20. UNDERTAKER Jones	ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 7196

Registered No. 18

County of Madison

City of Teton

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans P. Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: May (Month) 22 (Day) 1836 (Year)

7. AGE: 77 yrs. 8 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Ricks
(Address) Sugar City

15. Filed 2-27 1914 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1913 to Jan 25 1914 that I last saw him alive on Jan. 15 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hemorrage of the Brain

(Duration) ..... yrs. 1 mos. 15 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Thorpe M. D.

19 ..... (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	3/1 1914

20. UNDERTAKER	ADDRESS
John Phillips	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 719
Registered No. 19

1. PLACE OF DEATH.
County of Madison
City of Rexburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Delia S. Dudley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Mar. (Month) 28 (Day) 1854 (Year)

7. AGE: 59 yrs. 11 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Wm P. Tippetts

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Sophia Mead

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Delia D. Tiebaur
(Address) Rexburg

15. Filed 3-1 1914 L. L. Cope Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1913, to Feb 26 1914, that I last saw her alive on Feb 19 1914, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. L. Cope M. D.

19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton, Ida
DATE OF BURIAL: 3-3 1914

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH:
County of Madison
City of Hibland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 7195
Registered No. 20
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wayne Stratton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Bale

6. DATE OF BIRTH: Oct (Month) 6 (Day) 1912 (Year)

7. AGE: 1 yrs. [illegible] mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baker
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF FATHER: Eugene Stratton

11. BIRTHPLACE OF FATHER (State or Country): Kentucky -

12. MAIDEN NAME OF MOTHER: Mabel - Partrey

13. BIRTHPLACE OF MOTHER (State or Country): Rexburg Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eugene Stratton
(Address) R.F.D. 3 - Box

15. Filed 3 - 3 1914 — L. L. Espe, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1914 to Feb 28 1914, that I last saw him alive on Feb 28 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Empyema Both Lungs Tuberculosis of Oesophagus
Feb 28 Convulsions
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Espe M. D.
19 (Address) Denver.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	3/4 1914
20. UNDERTAKER	ADDRESS
[illegible]	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7191

Registered No. .....

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha L Fenton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.)
F	White	Widow

6. DATE OF BIRTH. Oct (Month) 18 (Day) 1832 (Year)

7. AGE 81 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Connecticut

10. NAME OF FATHER dont Know

11. BIRTHPLACE OF FATHER (State or Country) Scottland

12. MAIDEN NAME OF MOTHER dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Scottland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. E. Fenton

(Address) Rupert Idaho

15. Filed 2-10 1914

P. H. Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1914, to Feb 9 1914, that I last saw h[er] alive on Feb 9 1914, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Bronchus

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) P. H. Scott M. D.

2-14 1914 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Feb 10 1914
20. UNDERTAKER	**ADDRESS**
W. G. Goodman	Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. PTRS. & STRS. 24858

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7199

Name Martha L. Fenton

Date of Death Feb. 9. 1914.

Cause of Death Bronchio Pneumonia

Contributary Cause of death

(Sign here) O. L. Scott M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7201

Registered No. .....

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles A Turner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 19 (Day) 1852 (Year)

7. AGE: 62 Yrs. 11 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Ranchman

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Wont Known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Turner

(Address) Rupert Idaho

15. Filed 2-2 1914 R A Scott Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1914, to Feb 1 1914, that I last saw h alive on Jan 28 1914 and that death occured on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of bowels

(Duration) 1 Yrs. ? mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J B Kenagy M. D.

1914 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Feb 3 1914

20. UNDERTAKER: W G Goodman — ADDRESS: Rupert

IMPORTANT: Physician, fill in this page properly. Particularly the CAUSE OF DEATH and OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24653

[redacted]

County of Davis — File No. D 7211

City of Bassett — (No. ____ St.) — Registered No. 5

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Ella Lee

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in all cases. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single.

6. DATE OF BIRTH: Feb. 20 (Month) (Day) 1914 (Year)

7. AGE: ____ yrs. ____ mos. 1 hr ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. D. Lee

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Philadelphia Phillips

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. D. Lee

(Address) Bassett Idaho

15. Filed 2/23 191[illegible] J. P. Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 20 (Month) (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h____ alive on ____ 191__, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) .....

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) [illegible] M. D.

____ 19__ (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bassett — DATE OF BURIAL: 2-22 191[illegible]

20. UNDERTAKER: A Sayers — ADDRESS: Bassett

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2200
(No. ..... St.)

File No. 1202
Registered No. 4

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susan Nesja

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert Friel
(Address) Mullan, Ida.

15. Filed 2/8 1914 H. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...
and that death occured on the date stated above, at 8:30 M.
The CAUSE OF DEATH* was as follows:
Revolver wound of head - suicide
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) H. C. Mowery M. D.
Feb 3 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Hand Undertaking Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 122

Primary Registration District No. 2200.

File No. 7203

Registered No. 0

County of Shoshone

City of Wallace, Idaho. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oskar Kalehmdinn, Providence Hosp.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH

May 24, 1869
(Month) (Day) 1 (Year)

7. AGE

44 yrs. 8 mos. 7 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner,

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Finland,

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Finland,

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Finland,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oskar Kalehmdinn

(Address) Mullan, Idaho.

15.

Filed Feb 2 1914 H. J. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 31, 1914.
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1914, to Jan 31 1914

that I last saw him alive on Jan 31 1914

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Pericarditis

(Duration) yrs. 1/2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. Mowery M. D.

Feb 2 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mullan, Ida

DATE OF BURIAL: Febr 2 1914

20. UNDERTAKER: B.Z. Moreton

ADDRESS: Wallace Ida

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 720

Registered No. 6

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mamye Myrtle Degler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 6 Yrs. ..... Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Spokane Wash

10. NAME OF FATHER: E. E. Degler

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Ida C Noffsinger

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claude L Degler

(Address) Wallace Idaho

15. Filed 2/24 1914 K. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 23 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1914, to Jan 23 1914, that I last saw her alive on Jan 23 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Exposure

..... (Duration) ..... yrs. ..... mos. ..... ds.

2/ (Signed) K. C. Mowry M. D.

2/24/14 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Feb 25 1914

20. UNDERTAKER: Ward Undertaking Co. — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Cataldo

Registration District No. 97

Primary Registration District No. 21747

(No. ....., ... St.)

File No. 7205

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elmer Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 6 (Month) 12 (Day) 1880 (Year)

7. AGE: 32 Yrs. 10 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kan.

10. NAME OF FATHER: Wm Campbell

11. BIRTHPLACE OF FATHER (State or Country): South Dak

12. MAIDEN NAME OF MOTHER: Sarah West

13. BIRTHPLACE OF MOTHER (State or Country): Kan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Alley

(Address) Lapwai Ida

15. Filed Feb 16 1914 John M Alley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1912, to Feb 14 1914, that I last saw h— alive on Feb 14 1914, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John M Alley M. D.

2/14 1914 (Address) Lapwai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Idaho

Former or usual residence Melrose Ida

19. PLACE OF BURIAL OR REMOVAL: Melrose Ida — DATE OF BURIAL: Feb 16 1914

20. UNDERTAKER: J E Wallace — ADDRESS: Lapwai Ida

SYMS - YORK CO., PTRS. & BOKS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

File No. 7206
Registered No. 25
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William M Sunderlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 22" (Month) (Day) 1830 (Year)

7. AGE: 84 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranche
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Pelege Sunderlin

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Jane Cumfort.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Harris
(Address) Salmon Idaho.

15. Filed 2-20-14 191 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 18" (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1914, to Feby 18th 1914, that I last saw him alive on Feb 18th 1914, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Valvular Insufficiency of Heart

(Duration) Several yrs. ..... mos. ..... ds.
Contributory (Secondary) old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Whitwell M. D.
2-18 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemtery | DATE OF BURIAL: Feb 20" 1914

20. UNDERTAKER: J. C. Hacker | ADDRESS: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Hot Springs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 1201
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Brines Tolman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Exact date not known (Month) 1 (Day) (Year)

7. AGE
84 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Durand
(Address) Hot Springs

15.
Filed 2-20-14 191 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February 19" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 31 1914, to Feb. 19" 1914, that I last saw him alive on Feb. 18" 1914 and that death occurred on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows:
Central apoplexy

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Contributes from Exposure at time of attack
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Bratton M. D.
2/19 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: Feb 19" 1914

20. UNDERTAKER: J C Hacker — ADDRESS: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Patterson
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 2116
(No. ..... St.)

File No. 7208
Registered No. 21
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura DeLong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: August 7th 1907 (Month) (Day) (Year)

7. AGE: 6 yrs. 7 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lemhi Co. Idaho.

10. NAME OF FATHER: John DeLong

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Mary E. Kinser

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E. J. Campbell
(Address): Patterson Idaho.

15. Filed February 22 1914 Ella L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 4 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1914, to Feb 4 1914, that I last saw her alive on Feb 3 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) yrs. 3 mos. ds.
Contributory (Secondary) Pulmonary media
(Duration) yrs. mos. 7 ds.

(Signed) J. W. Kelley M. D.
Feb 19 1914 (Address) Challis Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: May Cemetery — DATE OF BURIAL: Feb. 6 1914

20. UNDERTAKER: Jno Black — ADDRESS: Patterson Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19700

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 41

Primary Registration District No. 2116

File No. 7209

County of Lemhi

City of Gibbonsville (No. ....., ... St.)

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christie Glennon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Do not know exact date (Month) (Day) (Year)

7. AGE: 42 yrs. ..... mos. ..... da.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: L. H. Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Do not know.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Glennon Jr.
(Address) Gibbonsville

15. Filed 3-6-14 191... Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 4" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Homicide
by means of blows inflicted upon head

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Doubler Coroner M. D.
3-5" 1914 (Address) Salmon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Gibbonsville March 6" 1914

20. UNDERTAKER Cemetery
Wm C Doubler

ADDRESS Salmon Ida.

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Gibbonville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. #1
Primary Registration District No. 2116

File No. 7210
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Glennan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Do Not Know exact date
(Month) (Day) (Year)

7. AGE
75 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Gen'l Miner
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Mass

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Glennan Jr
(Address) Gibbonville

15.
Filed 3-6-14 191...
Helen L. Smith Gov.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March - 4" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
By means of cutting Throat with Suicidal Intent

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Doebb Coroner ~~M. D.~~
3-5" 1914 (Address) Salmon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR [redacted] DATE OF BURIAL
Gibbonville March 5" 1914

20. UNDERTAKER Funeral Dir. ADDRESS
Wm C. Doebb Salmon Ida.

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 7211
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Exact data not known (Month) (Day) (Year)

7. AGE: 77 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor Work
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Smith

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Brockbank

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Smith
(Address) Salmon Ida.

15. Filed March 9 1914 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 11" 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

By means of Drowning, With Suicidal Intent

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Doebler Coroner. M.D.
3-9" 1914 (Address) Salmon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 3-9" 1914

20. UNDERTAKER: W. C. Doebler
ADDRESS: Salmon

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1213
Registered No. 64

1. PLACE OF DEATH.
County of Custer
City of Challis

Registration District No. 14
Primary Registration District No. 2061
(No. ....., ..., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Bradshaw

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: Sept 16 (Month) 1913 (Day) (Year)

7. AGE: ..... yrs. 5 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Jas Bradshaw

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Myrtle Bauno

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jas Bradshaw
(Address): Clayton

15. Filed 2/20/19 14 — C. L. Kirtley, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 19 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1914, to Feb 19 1914 that I last saw him alive on Feb 18 1914 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows: Membranous Croup

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Keeley M. D.
Feb 19 1914 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Challis	2/20 1914
20. UNDERTAKER	**ADDRESS**
Family	Challis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1213
Registered No. 3665

1. PLACE OF DEATH.
County of Custer
City of Challis
Registration District No. 14
Primary Registration District No. 2061
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Metzger

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widowed.

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1841 (Year)

7. AGE: 73 yrs. ..... mos. 13 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ben Metzger
(Address) Challis

15. Filed 2/26 1914 — [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1914, to Feb 24 1914
that I last saw h-er alive on Feb 24 1914
and that death occurred on the date stated above, at 2 p. M.
The CAUSE OF DEATH* was as follows:
Apoplexy

..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Kelley M. D.
Feb 24 1914 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Challis
DATE OF BURIAL: 2/26 1914

20. UNDERTAKER: friends
ADDRESS: Challis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. 721

Registered No. 17

County of Cassia

City of Burley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Mund Cheeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 23 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many 2 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Burley, Cassia Co, Ida

10. NAME OF FATHER: Albert M. Cheeley.

11. BIRTHPLACE OF FATHER (State or Country): West Va

12. MAIDEN NAME OF MOTHER: Ellie May Russell

13. BIRTHPLACE OF MOTHER (State or Country): West Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): A M Cheeley.
(Address): Burley Idaho

15.
Filed March 1st 1914 Prof. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) — 24 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-23- 1914, to 2-24 1914, that I last saw h.. alive on 2-24- 1914, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows: Cerebral Compression

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. T. Story M. D.

19 ..... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Feb 25 1914

20. UNDERTAKER: L. B. Galleghy ADDRESS: Burley. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 721
Registered No. 4

1. PLACE OF DEATH.
County of Lemhi
City of Winchester
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 48
Primary Registration District No. 2127
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Infant Putnam

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: February 7th 1914 (Month) (Day) (Year)

7. AGE: — yrs. — mos. — ds.
IF LESS than 1 day how many. 2 hrs 30 min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Winchester, Idaho

10. NAME OF FATHER: Charles O Putnam

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Eva Hiatt

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. O. Putnam
(Address) Winchester Idaho

15.
Filed 2-7-1914 Elton B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 7th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1914, to Febr 7 1914
that I last saw her alive on Febr 7th 1914
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Prematurity
Six months gestation

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elton B. Rogers M. D.
2-7-1914 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Home
DATE OF BURIAL: 2-8-1914

20. UNDERTAKER: None
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell Rural (No. ....., ... St.)

File No. 721

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Constance Blazer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	Widowed

6. DATE OF BIRTH: July 4 (Month) 1827 (Year)

7. AGE: 86 yrs. 7 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Paris France

10. NAME OF FATHER: Dont-Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Blazer
(Address) Nampa, Idaho.

15. Filed Feb. 17 1914 John D. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Dec 12 1914, that I last saw h[illegible] alive on Dec 12 1914, and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Cole M. D.
2/17 1914 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida. DATE OF BURIAL: 2/17 1914

20. UNDERTAKER: W. E. Dyer ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 721
Registered No. 10

1. PLACE OF DEATH.
County of Canyon
City of Caldwell Rural (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Van Valkenburgh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow

6. DATE OF BIRTH: December (Month) 18 (Day) 1826 (Year)

7. AGE: 87 yrs. 1 mos. 28 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Richard Moote

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Youmans

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Page Munger
(Address) Caldwell Idaho

15.
Filed Feb. 17 1914
John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191..., to Feb. 15 1914, that I last saw h.. alive on Feb 15 1914, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of face

(Duration) 15 yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Coe M. D.
2/17 1917 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge | DATE OF BURIAL: 2/18 1914

20. UNDERTAKER: W. C. Dyer | ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 3005

File No. 722
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nettie Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W.	Married

6. DATE OF BIRTH: April (Month) 5 (Day) 1893 (Year)

7. AGE: 40 yrs. 10 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Louisiana Mo.

10. NAME OF FATHER: J. S. Hickey

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Catharine McNutt

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mark Price
(Address) Kennedale

15.
Filed Feb. 19th 1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-15 1914, to 2-18 1914, that I last saw h... alive on 2-17 1914, and that death occurred on the date stated above, at 5 PM.

The CAUSE OF DEATH* was as follows:
Bronchs-Pneumonia
Diabetis, Mellitis

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Bonnell M. D.
2-19-1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 2/19 1914

20. UNDERTAKER: W. A. Dyer
ADDRESS: Caldwell, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7221
Registered No. 12

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Daugherty

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: May (Month) 19 (Day) 1851 (Year)

7. AGE: 62 yrs. 8 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife.
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: David Hale.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sarah Hale.

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Daugherty
(Address) Caldwell Ida.

15. Filed Feb. 25 1914 John D. Myers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1914, to Feb. 23 1914 that I last saw her alive on Feb. 23 1914 and that death occurred on the date stated above, at 12. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis -
Uremic Poisoning -

..... (Duration) Not known yrs. ..... mos. ..... ds.
Contributory (Secondary) Oedema of Lungs -
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Cole M. D.
2/25 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cemetery
DATE OF BURIAL: 2/25/1914

20. UNDERTAKER: Platt Peckham Co.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

File No. 1229

Registered No. 13

County of Canyon

City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie Lawrence

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Married

6. DATE OF BIRTH: July (Month) 14 (Day) 1880 (Year)

7. AGE: 33 yrs. 7 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pulaski Va

10. NAME OF FATHER Wm Matthews

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Elizabeth Sutton

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G T Lawrence
(Address) Caldwell

15. Filed May 5 - 1914 John J. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1914, to March 4 1914 that I last saw h.. alive on March 4 1914 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Miller M. D.

3/5 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3/5 1914

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-26-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7223
Registered No. 2

1. PLACE OF DEATH.
County of Canyon
City of New Plymouth
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 1009

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lillian Hunagn.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
f	W.	Infant

6. DATE OF BIRTH: Mch (Month) 30 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Richard T. Hunagn.

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Dora Boyd.

13. BIRTHPLACE OF MOTHER (State or Country) Arkansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. T. Hunagn.
(Address) New Plymouth Ida

15. Filed ..... 191... Wm T. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h[illegible] alive on Mch 29 1914,
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Atalectasis.

(Duration) ..... yrs. ..... mos. 24 ds.
Contributory (Secondary) Imperfect foetal development

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm T. Drysdale M. D.
Mch 30 1914 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida — DATE OF BURIAL: Mch 31 1914

20. UNDERTAKER: Neighbors made a casket. — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ..., ... St.)

File No. 7225
Registered No. 21
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Maggie Holden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 19 (Day) 81 (Year)

7. AGE: 32 yrs. 10 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J M Belshaw

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Susan Holden

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L D Arnold
(Address) Moscow

15. Filed Mch 27 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191...
that I last saw h... alive on ... 191...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. K. Clarke M. D.
19... (Address) Court House

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: Mch 27 1914

20. UNDERTAKER: Geo Hilty
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 7226
Registered No. 22

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., St.) Brady
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Marcia Marie
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fm
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: March 26 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. / ds.
IF LESS than 1 day how many *I. O. hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow Ida.

10. NAME OF FATHER: E. W. Brady

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Anna Brandt

13. BIRTHPLACE OF MOTHER (State or Country): Spokane Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julius E. Brandt Jr.
(Address) Moscow Ida

15. Filed Feb 28 1914 J. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch 28 — 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 26 — 1914, to Mch 28 1914, that I last saw h[illegible] alive on Mch 27 1914 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage (Premature delivery)

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wirt M. D.
Mch 28 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 3/29 1914

20. UNDERTAKER: Geo Stolz | ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 1221
Registered No. 18

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Not Named

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: March 18 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 30 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow

10. NAME OF FATHER Alfred M Rodgers

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Bessie Pearl Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A M Johnson
(Address) Moscow

15. Filed March 20 1914 D F Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 19 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1914, to March 19 1914, that I last saw him alive on March 19 1914 and that death occurred on the date stated above, at 10.20 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
5 months

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D F Rae M. D.
March 20 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: March 20 1914

20. UNDERTAKER: J M Rodgers Rodgers — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 7228
Registered No. 17
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Scribner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Widower

6. DATE OF BIRTH
Feb 10 (Month) (Day) 1844 (Year)

7. AGE
70 yrs. 1 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Labor
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Maine

10. NAME OF FATHER Natanial Scribner

11. BIRTHPLACE OF FATHER
(State or Country) Maine

12. MAIDEN NAME OF MOTHER Moore (Nellie)

13. BIRTHPLACE OF MOTHER
(State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna Bach
(Address) Kent, Wash.

15.
Filed Mch 21 1914 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1914, to March 21 1914, that I last saw him alive on March 20 1914, and that death occurred on the date stated above, at 5.20 P.M.

The CAUSE OF DEATH* was as follows:
Mitral lesion
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Gutman M. D.
3-21 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: March 21 1914

20. UNDERTAKER: Geo Stoltz — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. ( )
Primary Registration District No.
(No. ; St.)

File No. 7229
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ewald R. Erickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Feb (Month) 15 (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 6 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Moscow

10. NAME OF FATHER M E Erickson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Anna Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M E Eriksson
(Address) Moscow Idaho

15. Filed March 23 1914 — D. F. Rae, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 14 1914, to Mch 21 1914, that I last saw him alive on Mch 21 1914, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) — yrs. — mos. 6 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. C. Wilt M. D.
Mch 22 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 3/23 1914

20. UNDERTAKER: Leo Stolz — ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of
(No. , St)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
File No. 7230
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Leroy Meeks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1844 (Year)

7. AGE: 69 yrs. 5 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Saw-milling
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: michael Meeks

11. BIRTHPLACE OF FATHER (State or Country): new york

12. MAIDEN NAME OF MOTHER: Mary Irish

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Claire L. Meeks
(Address) Viola Idaho

15. Filed Mch 31 1914 J. F. Rau Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1914, to Mar. 31 1914, that I last saw h[illegible] alive on Mar 29 1914 and that death occurred on the date stated above, at 5.20 P. M.

The CAUSE OF DEATH* was as follows:

Internal Hemorhage
3 hrs.
(Duration) yrs. mos. ds.
Contributory (Secondary) Operation appendicitis
(Duration) yrs. mos. 30 ds.

(Signed) Geo Bayha M. D.
Mch 30 1914 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Viola Idaho
DATE OF BURIAL: April 2 1914
20. UNDERTAKER: E Anderson
ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 7231
Registered No. 20

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rufus M Bowles
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1856 (Year)

7. AGE: 57 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: merchant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: Samuel Bowles

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel C Bowles
(Address) Viola

15. Filed Mch 9 1914 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21 1914 to Mch 7 1914
that I last saw him alive on Mch 7 1914
and that death occurred on the date stated above, at 5. P. M.
The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Dilatation of right side of heart

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. N. Clarke M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Viola — DATE OF BURIAL: March 9 1914

20. UNDERTAKER: Leo Stitz — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 7232
Registered No. 79

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Luisa Carey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fm	White	Married

6. DATE OF BIRTH: Feb. (Month) 20 (Day) 1855 (Year)

7. AGE: 59 yrs. 0 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Harrison Miss.

10. NAME OF FATHER: Patrick Little

11. BIRTHPLACE OF FATHER (State or Country): Co. Mede Ireland

12. MAIDEN NAME OF MOTHER: don't know

13. BIRTHPLACE OF MOTHER (State or Country): don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas C. Carey
By Nelle Carey
(Address) Moscow Ida.

15. Filed Mch 19 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1914, to ..... 191..., that I last saw her alive on March 17 1914, and that death occurred on the date stated above, at 12 20 M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Gritman M. D.
19... (Address) Moscow Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New London Mo. | DATE OF BURIAL: March 20 1914

20. UNDERTAKER: Geo Skelly | ADDRESS: moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7233

Registered No.

1. PLACE OF DEATH.
County of Latah.
City of Potlatch.

Registration District No. 65.
Primary Registration District No. 2145.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fredaberg. C. Severin.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH: March. 21 1914
(Month) (Day) (Year)

7. AGE: ..... yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..14.. hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry business or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Carson Severin.

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Vandler. Ström.

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carson Severin.
(Address) Potlatch. Idaho.

15.
Filed March. 23rd, 1914 Dr. J.W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March. 22nd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March. 21 1914, to March. 22 1914
that I last saw he alive on March. 21 1914
and that death occurred on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:

Immaturus. Stillborn.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Premature birth.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.W. Thompson. M. D.
March 23 1914. (Address) Potlatch.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery
DATE OF BURIAL: March. 23 1914

20. UNDERTAKER: Parents.
ADDRESS: Potlatch.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Potlatch.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65.
Primary Registration District No. 21 45.
(No. ....., ... St.)

File No. 7234
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma M St Clair Sinclair

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Mar (Month) 16 (Day) 1914 (Year)

7. AGE: 27 yrs. 8 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jac Shields

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James L. Sinclair
(Address) Potlatch Idaho

15.
Filed March 16th 1914 J. W. Thomson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March. 16 1914, to March. 16 1914, that I last saw her alive on March. 16th 1914, and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:
Acute nephritis -
causing edema of Lungs -

(Duration) ..... yrs. ..... mos. 6 hours

Contributory (Secondary): Puerperal - State.
(Duration) ..... yrs. 7 mos. ..... ds.

(Signed) J. W. Thomson M. D.
March 16 1914 (Address) Potlatch.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ REMOVAL: Shambaugh. Iowa. | DATE OF BURIAL: March. 1914

20. UNDERTAKER: E. Anderson - | ADDRESS: Palouse. Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1012-2017
(No. ....., ... St.)

File No. 7235
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel F Graham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
April (Month) 19 (Day) 1855 (Year)

7. AGE
58 yrs. 10 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) ~~Iowa~~ Ohio

10. NAME OF FATHER Jno Jackson Graham

11. BIRTHPLACE OF FATHER
(State or Country) Penn.

12. MAIDEN NAME OF MOTHER Sara Ann Grumman

13. BIRTHPLACE OF MOTHER
(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno T. Graham
(Address) Jerome Ida

15.
Filed Mar 15 1914
E. D. Pyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar 13 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1914, to Mar 13 1914, that I last saw him alive on Mar 11 1914, and that death occurred on the date stated above, at 9 15 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of lower bowels
Stomach Omentum

(Duration) ..... yrs. ..... mos. 18 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F Schmerhall M. D.
Mar 14 1914 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Ida
DATE OF BURIAL: 3-15-1914

20. UNDERTAKER: Chas J. Crosby
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017 2017
(No. ..... St.)

File No. 1236
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seth S. Reid

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
m	white	married

6. DATE OF BIRTH
Oct (Month) 25 (Day) 1867 (Year)

7. AGE
47 yrs. 7 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bath Maine

10. NAME OF FATHER Samuel S. Reid

11. BIRTHPLACE OF FATHER (State or Country) Bath Maine

12. MAIDEN NAME OF MOTHER Sarah E Reid

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Seth S Reid
(Address) 9 mi SW of Jerome Ida

15.
Filed Mar 19 1914 E. D. Pipes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1914, to Mar 17 1914, that I last saw h in alive on Mar 17 1914, and that death occurred on the date stated above, at 4p M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 8 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. D. Pipes M. D.
Mar 19 1914 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary — DATE OF BURIAL: Mar 19 1914

20. UNDERTAKER: D W Stevenson — ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017
(No. ....., ... St.)

File No. 7237
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME unnamed Claypool

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Mar (Month) 13 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: aaron W Claypool

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Viola Kidd

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Aaron W. Claypool
(Address) 8 mi. SE of Jerome

15.
Filed Mar 15 1914 E. D. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1914, to Mar 15 1914, that I last saw h[illegible] alive on Mar 14 1914, and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:
Weakling at Birth
absence of normal Vitality

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. D. Piper M. D.
Mar 15 1914 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary | DATE OF BURIAL: Mar 1[illegible] 1914

20. UNDERTAKER: [illegible] | ADDRESS: Jerome

SYMS - YORK CO., PTRS. & BDRS. 19760

FOR[illegible]V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7238

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Lincoln

City of Jerome

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Sarah Jane Robinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wife

6. DATE OF BIRTH. May 3rd (Month) (Day) 1841 (Year)

7. AGE: 68 Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Ace Dexter

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Sarah Jane Whitfield

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. R. Robinson

(Address) Jerome Ida

15. Filed Mar 30 1914 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1914, to March 29 1914, that I last saw her alive on Mar 29 1914, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Thurt Schmeckebier M. D.

19..... (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: 1914

20. UNDERTAKER: C. A. Crowley — ADDRESS: Twin Falls

481

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Burke 6 mi West.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39
Primary Registration District No. 2081
(No. ....., ... St.)

File No. 7230
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. R. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
June (Month) 1 (Day) 1863 (Year)

7. AGE
51 yrs. 2 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER Thos Miller.

11. BIRTHPLACE OF FATHER (State or Country) W. Va.

12. MAIDEN NAME OF MOTHER Mrs Penn

13. BIRTHPLACE OF MOTHER (State or Country) Dont. know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J R Miller
(Address) Burke Ida.

15.
Filed 3/23 1914 J. T. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar. (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1914, to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Acute dilitation of heart.
& Post Mortem findings

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Kidney Disease
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Murphy M. D.
3-22 1914 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Burke Ida — DATE OF BURIAL: 3/23 1914

20. UNDERTAKER: H B Evans — ADDRESS: Burke Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7240

Registered No. 2

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. 5, [illegible] St.)

2. FULL NAME Frank E Price

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 20 (Day) 1860 (Year)

7. AGE: 53 yrs. 7 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book Keeper +
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William Price

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Packabarry

13. BIRTHPLACE OF MOTHER (State or Country): Eng Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Creighton
(Address) Payette Ida

15. Filed Jan 7 1914 J. O. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28 1914, to ~~Feb. 5~~ Mar. 5 1914, that I last saw him alive on Mar. 5. 1914, and that death occurred on the date stated above, at 1:30 p M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) yrs. 4 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. H. Avery M. D.
3/7/1914 (Address) Payette

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: Mar 8 1914

20. UNDERTAKER: J. A. McClair | ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 741
Registered No. 3

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Chesley Sharp

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 10 (Day) 1914 (Year)

7. AGE: X yrs. X mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. S. Sharp

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Mary Frakes

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Sharp
(Address) Payette

15. Filed March 8 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 5 1914, to Mar. 8 1914, that I last saw him alive on Mar 8 1914 and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Acute Capillary Bronchitis
✓
✓
(Duration) ✓ yrs. ✓ mos. 4 ds.

Contributory (Secondary) ✓
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R. O. Payne M. D.
3/9 1914 (Address) Ontario Ore.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho | DATE OF BURIAL: Mar 9 1914

20. UNDERTAKER: D. A. Cudaw | ADDRESS: Payette Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. , St.)

File No. 1743
Registered No. 74

2. FULL NAME Infant Howard.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Mar (Month) 16 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 4 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Howard.

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Effie Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Howard
(Address)

15. Filed Mar 21, 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 21st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1914 191 , to Mar. 21, 1914 191 , that I last saw her alive on Mar. 20th, 1914 191 , and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Haematemesis

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

3/21 1914 (Address) Payette, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: Mar 22 1914

20. UNDERTAKER: D. N. Adair | ADDRESS: Payette Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 7243
Registered No. 2

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Cecilia Montague
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Feminine
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: April (Month) 6 (Day) 1858 (Year)

7. AGE: 55 yrs. 11 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Innkeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: James Mahoney

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Catherine Kedigan

13. BIRTHPLACE OF MOTHER (State or Country): Massachusetts

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. M. Montague
(Address) Genesee Idaho

15.
Filed 3-29 1914 O. N. Eklew
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23 1914, to Mar 27 1914
that I last saw h[illegible] alive on Mar 27 1914
and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:

Peritonitis
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Purulent Pleurisy
(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) C. F. Tuomy M. D.
Mar 29 1914 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cedar Grove | DATE OF BURIAL: March 30-1914

20. UNDERTAKER: F. E. Lambert | ADDRESS: Genesee Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 2142

File No. 7244
Registered No. 62
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Unknown (Month) 1855 (Day) (Year)

7. AGE
59 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Pelo
(Address) Genesee Idaho

15.
Filed Mch. 16 1914 W. H. Eheu
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
3 (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-14- 1914 to 3-15 1914
that I last saw h— alive on 3-15 1914
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Uremic Coma
.....
.....
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Chronic Alcoholism
(Duration) 40 yrs. ..... mos. ..... ds.
(Signed) W. H. Eheu M. D.
3-16 1914 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. | DATE OF BURIAL: 3-17 1914

20. UNDERTAKER: J. E. Lambert | ADDRESS: Genesee Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 57

Primary Registration District No.

File No. 7245

County of Bear Lake

City of St Charles. (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Adeline Alfred Booth.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed.

6. DATE OF BIRTH: Dec. (Month) 20 (Day) 1844 (Year)

7. AGE: 67 yrs. 2 mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nauvoo Ills

10. NAME OF FATHER: William M. Alfred.

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Clarissa A. Bates Alfred.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. Alfred.
(Address) St Charles

15.
Filed March 10 1914 John Mattson. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart Failure.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles. DATE OF BURIAL: Feb 27 1914.

20. UNDERTAKER: J A Blade ADDRESS: St Charles

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4 7246

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1014

County of Ada

City of Boise (No. 612, Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob R. Bowers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 28 (Day) 1840 (Year)

7. AGE: 73 yrs. 8 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Wm Bowers

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah A. Bowers
(Address) Boise Ida

15.
Filed 2-27 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 25 (Day), 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1914 to Feb 25 1914 that I last saw him alive on Feb 25 1914 and that death occurred on the date stated above, at 11:15 PM

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. L. Falk M. D.

2/26 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery | DATE OF BURIAL: Feb. 28 1914

20. UNDERTAKER: Schreiber & Ledeen | ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 51 7248

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Slocum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Widow

6. DATE OF BIRTH: not Obtainable (Month) (Day) 1853 (Year)

7. AGE: 60 yrs. ____ mos. ____ ds. IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): not Obtainable

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Slocum.
(Address) Jerome

15. Filed 3/2 1914 W. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 28th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/25th 1914, to 2/27 1914, that I last saw her alive on 2/27 1914 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Breast

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Fred A Tourtellotte M. D.
2/28 1914 (Address) Lucky Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. 5 days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death? ____
Former or usual residence Jerome, Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome, Idaho.	3/2 1914

20. UNDERTAKER	ADDRESS
Schreiber & Siebenpfaden	Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO. PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No. 2004

City of

(No. Ada Co. Blacks Creek St.)

File No. 7-7249

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Prow

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 1 (Day) 836 (Year)

7. AGE: 77 yrs. 3 mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Phil Prow

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Mahaley Bodenhome

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Logan Price
(Address) Meridian

15.
Filed 2-5 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ ~~dead~~ ~~19..~~ to Feb. 4 1914 ~~that I last saw he alive on 19..~~ and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
No Doctor in attendance after inquiries find cause of death Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Old Age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Adolph Schreiber M. D.
19.. (Address) Boise Ada Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Feb. 5 1914

20. UNDERTAKER: Schreiber & Hidenfeldt — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

7250

File No. 7250

Registered No. 47

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 1014½ Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John D. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not obtainable (Month) 1 (Day) (Year)

7. AGE: about 30 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): a

12. MAIDEN NAME OF MOTHER: a

13. BIRTHPLACE OF MOTHER (State or Country): a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Schreiber
(Address) Boise

15. Filed 2-27 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ saw dead Feb 14 1914, to ~~101~~, ~~that I last saw him alive on 101~~ and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Was found dead in bed
cause of death unknown

(Duration) yrs. mos. ds.

Contributory (Secondary): Was a heavy drinker and drug fiend.

(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber Coroner Ada Co
Feb 27 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill-County Plat | DATE OF BURIAL: Feb. 28 1914

20. UNDERTAKER: Schreiber & Siddons | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 8425

Registered No.

County of Ada

City of near Eagle (No. near Eagle Ada County)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret McClurg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov 9th 1833 (Month) (Day) (Year)

7. AGE: 80 yrs. 2 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ills.

10. NAME OF FATHER: Benj. Wooley

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. McClurg
(Address)

15. Filed February 7th 1914 W. E. Pike Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 7th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2 1914, to Feb. 6th 1914, that I last saw her alive on Feb. 6 1914 and that death occurred on the date stated above, at 1:30 PM

The CAUSE OF DEATH* was as follows:
Senile Debility

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Froom M. D.
2-7-1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence: Eagle Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/8 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1914
68
1846

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 7252

County of Ada

City of Boise

(No. 3 Miles N.E. of Boise St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Staats Staats

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Marriage

6. DATE OF BIRTH: June (Month) 20 (Day) 1846 (Year)

7. AGE: 68 yrs. 7 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Staats

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Myra Roberts

13. BIRTHPLACE OF MOTHER (State or Country): dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C N Wallis
(Address) 419 So. 4th St Boise

15.
Filed 2-16 1914 W S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead ~~19__ to~~ saw ~~19__~~, ~~that I last saw him alive on~~ Feb. 14th 1914 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Ur Physician in attendence was dead about 4 hours when I arrived. Cause of Death unknown.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Adolph Schreiber M.D.
19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Feb. 16 1914

20. UNDERTAKER: Schreiber & Anderson | ADDRESS: Boise Ada

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 7253
Registered No.

1. PLACE OF DEATH.
County of Ada
City of 3 Miles E of Boise (No. near Holcomb School St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Eskelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 28th (Day) 1914 (Year)

7. AGE: ___ yrs. ___ mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada County, Idaho.

10. NAME OF FATHER: Peter Eskelson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Emma Paulson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Eskelson
(Address) Boise Idaho

15. Filed 2/28 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 27th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1914 to Feb 27th 1914 that I last saw h[im] alive on Feb 25th 1914 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Malconcealation consequent death due to nonclosure of foramen ovale
(Duration) ___ yrs. ___ mos. ___ ds.
Contributory (Secondary)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Chas Bond M. D.
Feb 28 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 2/28 1914

20. UNDERTAKER: Schreiber & Hedegaden | ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 17254
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Boise (No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Augustus E Eggman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Feb (Day) 2 (Year) 1842

7. AGE: 72 Yrs. ... Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER John Eggman

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Mary Morgan

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. G. Burnett
(Address) Boise Ida

15. Filed 2/28 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) 2 (Day) 27 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1913, to Feb 27 1914, that I last saw him alive on Feb 25 1914 and that death occured on the date stated above, at 12 30 PM.

The CAUSE OF DEATH* was as follows:
Chronic Progressive Bulbar Paralysis

(Duration) 1 Yrs. ... mos. ... ds.
Contributory (Secondary) Senility
(Duration ... yrs. ... mos. ... ds.

(Signed) Fred A Pettyjohn M. D.
2/28 1914 (Address) Falk Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: Mar 1 1914

20. UNDERTAKER: Terry Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 27 7255

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 917 N. 7th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth B. L. Richie

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 22nd (Day) 1913 (Year)

7. AGE: ~~0~~ 11 Mos yrs. mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City, Utah

10. NAME OF FATHER: C. W. Richie

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Bessie Roarke

13. BIRTHPLACE OF MOTHER (State or Country): Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Richie
(Address) Boise, Idaho

15.
Filed February 1st, 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 31st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1914, to Jan 31 1914, that I last saw her alive on Jan 31 1914, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Gastritis

(Duration) yrs. mos. 2 ds.

Contributory (Secondary): Nursing mother with mastitis

(Duration) yrs. mos. 13 ds.

(Signed) Jos R Rumbarger M. D.

Feb 1 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence 917 N. 7th Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 2/1 1914

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise. Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3/7258

Registered No.

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of South Boise (No. Maple & Manitou St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H. Mead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Not obtainable (Month) (Day) 1 (Year)

7. AGE: about 65 Years yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chicken Raiser
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not obtainable

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Schneider
(Address) Boise

15.
Filed 2 - 6 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1914, to Feb 3 1914, that I last saw him alive on Feb 3 1914 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) Morphine Poisoning

(Duration) 40 yrs. — mos. — ds.

(Signed) R. P. Glasse M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Feb. 6 1914

20. UNDERTAKER: Schneider & Anderson Jnc.

ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1014

File No. 33 7259

County of Ada

City of Boise (No. Pinney Theatre St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Alonzo Pinney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (or the word)

6. DATE OF BIRTH: Sept. (Month) 29th (Day) 1835 (Year)

7. AGE: 78 yrs. 5 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Theatrical
(b) General nature of industry business, or dstablishment in which employed (or employer): Mer. Business

9. BIRTHPLACE (State or Country): Franklin County, Ohio

10. NAME OF FATHER: Charles Pinney

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Sarah Fuller

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Parker Pinney Ferguson
(Address) Pinney Theatre

15. Filed 2-7 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 4th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1914, to Feb 4 1914, that I last saw h... alive on ... 191.. and that death occurred on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows:
Thrombus of heart

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo Cornett M. D.

19.. (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs 2 mos 26 days. In the State 52 yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Feb. 8 1914

20. UNDERTAKER: Schreiber & Hildebrandt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35 7269
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 100 F
(No. 1 E Jackson St. Hospital St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin M. Higgs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan — 19 — 1873 (Month) (Day) (Year)

7. AGE: 40 yrs. 11 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Elvirt Higgs

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Rachel Baird

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nelson B Higgs
(Address) Horseshoe Bend

15.
Filed 2 — 9 — 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1914, to Feb 6 1914, that I last saw h alive on Feb 6 1914 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Alcoholism
Acute alcoholic delerium

(Duration) 1 d yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Maurice Hamilton M. D.
2/9 1914 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Feb 9 1914

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 36 7261

County of

City of Boise

(No. 112, East Bannock St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Marion Stott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 26 (Day) 1851 (Year)

7. AGE: 62 yrs. 3 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Chas Stott

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizibeth Owen

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Stott
(Address) Meridian Idaho

15.
Filed 2-10 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1913, to Feb 9 1914, that I last saw him alive on Feb 8 1914, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Obstructive Jaundice

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) Carcinoma of Pancreas

(Duration) 1 yrs. ... mos. ... ds.

(Signed) J. E. Troon M. D.

2-9 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs. ... mos. 7 days.

Where was disease contracted if not at place of death?

Former or usual residence Star Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 10 1914

20. UNDERTAKER — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7262

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 112, East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Sundstrom

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not obtainable (Month) (Day) 1 (Year)

7. AGE: About 50 Years ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adolph Schneider Coroner

(Address) Boise

15.

Filed 2-10 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 5 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1914, to Feb 5 1914, that I last saw h— alive on Feb 5 1914 and that death occurred on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Bronchitis

Jaundice

Pneumonia

(Duration) ..... yrs. ..... mos. 4 days ds.

Contributory (Secondary) Accomplice Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Lee Hunt M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery Co Plot | DATE OF BURIAL: Feb. 12 1914

20. UNDERTAKER: Schneider & Sidenfaden | ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

D. C. Stewart

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2
County of Ada Primary Registration District No. 1004
City of Boise (No. 219, W. Byrneys Ave St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 39 7263
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. C. Haynes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: March (Month) 27 (Day) 1837 (Year)

7. AGE: 76 yrs. 10 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): Stage Driver

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Fredenburgh
(Address) Shoshone Idaho

15. Filed 2 - 21 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 22 1914, to Feby 20 1914
that I last saw h alive on 191
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Geo Callister M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..1..mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Shoshone Ida

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shoshone Ida	Feb. 22 1914
20. UNDERTAKER	ADDRESS
Schreiber & Hickenlooper	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40726
Registered No.

1. PLACE OF DEATH.
Registration District No. 7
Primary Registration District No. 1004
County of Ada
City of Boise (No. 120, Broadway St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Carroll

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... 1840 (Month) (Day) (Year)

7. AGE: 74 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: James Howe

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Clarie ~~not Ablamobe~~

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. Carroll
(Address) Boise Ida

15. Filed 2-21 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 21st 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16th 1914, to Feb 21st 1914, that I last saw her alive on Feb 18th 1914 and that death occurred on the date stated above, at 11:45 M.

The CAUSE OF DEATH* was as follows:
Dilatation of Heart caused from Chronic Heart Disease and Asthma
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Asthma - Valvular Heart Trouble
(Duration) 2 months yrs. ..... mos. ..... ds.
(Signed) John Bouch M. D.
19 ..... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence 120 Broadway, Boise Ida

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery
DATE OF BURIAL: 2/22 1914

20. UNDERTAKER: Schreiber & Eidenfaden
ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41 7265

Registered No:

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 417 Washington St.)

2. FULL NAME Jacob J. Maurer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb 21st 1914
(Month) (Day) (Year)

7. AGE: ___ yrs. ___ mos. ___ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Jacob H Maurer

11. BIRTHPLACE OF FATHER (State or Country): So Dakota

12. MAIDEN NAME OF MOTHER: Cora M. Fletcher

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob H Maurer
(Address) Boise, Ida

15.
Filed Feb. 22nd, 1914 C. E. Wilson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 21st 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth
7 months
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Sprenger M. D.
19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos 1 days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence 620½ N. 9th Boise, Ida

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery
DATE OF BURIAL: 2/23 191...

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise (No. 1213 Bannock St.)

File No. 42 7266

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Harden

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Feb. (Month) 21 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: Loyd Harden

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Jennie King

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lloyd Harden
(Address) Boise

15.
Filed Feb. 23rd, 1914 M. E. Powell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/21 1914, to 2/23 1914, that I last saw h[illegible] alive on 2/23 1914 and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Unknown
Congenital defect in respiration
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Patterson M. D.
2/23 1914 (Address) [illegible] Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem. Plat.	Feb. 23 1914

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-28 M. 1-16-28

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43 7267

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise,

(No. 609 N 16 St. St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

2. FULL NAME Lewis Weber Grubb

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 30 (Day) 1853 (Year)

7. AGE: 60 Yrs. 9 Mos. 22 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Clothing Salesman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Lewis Grubb

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Marie Snyder

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Anna Grubb
(Address) 609 N 16 St

15. Filed Feb. 23rd, 1914. [signature] Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1914, to Feby 23 1914, that I last saw h-m alive on Feby 20 1914 and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Cancer of Prostate
.....(Duration) .....Yrs. 8 mos. .....ds.
Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.

(Signed) James L Wood M. D.
Feb 23 1914. (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emma Penn — DATE OF BURIAL: Mar 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 321, Grove St.)

File No. 4726

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alma Gregory

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ——— (Month) ——— (Day) 1867 (Year)

7. AGE: 47 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Gregory
(Address) Boise

15.
Filed 2-24 1913 M L Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23-a14AM 191 , to Feb 23-a16AM 1914, that I last saw h[illegible] alive on Feb 23-a1430 1914, and that death occurred on the date stated above, at 6.30 M.

The CAUSE OF DEATH* was as follows:

Unknown

..... (Duration) ——— yrs. ——— mos. 2 hours ds.

Contributory (Secondary) ..... (Duration) ——— yrs. ——— mos. ——— ds.

(Signed) J. Carl Hill M. D.

Feb 23 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ——— yrs. ——— mos. 2 hours days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Caldwell Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Feb. 24 191..

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1814

File No. 4259

County of Ada

City of Boise

(No. Idaho Soldiers Home St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Donaldson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 5 (Day) 1842 (Year)

7. AGE: 72 Yrs. 1 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: James Donaldson

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Matilda Sprowl

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Mary E. Donaldson

(Address) Boise Idaho

15. Filed 2-25 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 26th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 28th 1913, to February 26 1914, that I last saw h[illegible] alive on the morning of Feb 26 1914, and that death occured on the date stated above, at 7-45 A. M.

The CAUSE OF DEATH* was as follows:

Sarcoma of the Abdomen

(Duration) two Yrs. mos. ds.

Contributory (Secondary) Intestenal Trouble

(Duration yrs. mos. ds.

(Signed) Mary E. Donaldson M. D.

19.... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days 2 In the State Idaho 6 mos. 2 days

Where was disease contracted if not at place of death? Knoxville Tenn.

Former or usual residence Knoxville Tenn.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill

DATE OF BURIAL: Feb 26 1914

20. UNDERTAKER: Troy & Summers

ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. Room 7 Pacific Hotel St.)

File No. 4672

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Millard F. VanHooser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 19 (Day) 1880 (Year)

7. AGE: 33 Yrs. 4 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: G. M. VanHooser

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Matilda Ray

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. R. VanHooser
(Address) 1017 W. Jeff Boise Ida.

15.
Filed 2-27 1914
M S Parker
Local Registrar

BYMS - YORK BD., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26 12 05, to Feb. 26 1914, that I last saw h[illegible] alive on Feb. 26 1914, and that death occured on the date stated above, at 12 05 P.M.

The CAUSE OF DEATH* was as follows:
Gun shot wound of abdomen inflicted by himself
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Suicidal intent
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Adolph Schreiber M. D.
19..... (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dickson Springs Cem. DATE OF BURIAL: Mch 3 1914

20. UNDERTAKER: Troy Summers ADDRESS: Boise Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7271
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Star
(No. , St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John F. Benfael

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: December 13 (Month) 13 (Day) 1847 (Year)

7. AGE: 66 yrs. 2 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: House carpenter
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Putmen Co Indiana

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs B. Benfield
(Address)

15. Filed Mar 2 1914 C A Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 1. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1912, to Mch 1 1914 that I last saw h[illegible] alive on March 1 1914, and that death occurred on the date stated above, at 11.16 P M.

The CAUSE OF DEATH* was as follows:
Chronic Bright's Disease
" Cystitis & Orchitis
(Duration) 2 yrs. 7 mos. 7 ds.
Contributory (Secondary) Cystitis & Orchitis
(Duration) 2 yrs. mos. ds.
(Signed) C A Hall M. D.
(Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death None yrs. mos. ds. In the State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: DATE OF BURIAL Mch 3 1914

20. UNDERTAKER: J L Ayres ADDRESS Star Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7272

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1002

Primary Registration District No.

(No. ....., ... St.)

2. FULL NAME Eva M. Gaylord

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feby (Month) 28 (Day) 96 (Year)

7. AGE: 18 yrs. ..... mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Henry George

11. BIRTHPLACE OF FATHER (State or Country): Don Kriga

12. MAIDEN NAME OF MOTHER: Mary Ross

13. BIRTHPLACE OF MOTHER (State or Country): North Brand

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J L Ayres
(Address) Star Idaho

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 18 1914, to Mar 1914 that I last saw h[er] alive on Feby 28 1914, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Tuberculosis of Lungs

(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J F Miller M. D.
Mar 3 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary — DATE OF BURIAL: Mar 3 1914

20. UNDERTAKER: J. L. Ayres — ADDRESS: Star Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 727.3
Registered No. 1

1. PLACE OF DEATH.
County of Ada
City of Star, (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 2001

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Elmer Markley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Feby (Month) 20 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds. 22 hrs. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Star, Ada Co Idaho

10. NAME OF FATHER: Charles A. Markley

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rosa P. Gilman

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): CO Markley
(Address): .....

15. Filed Feby 24 1914 O O Hall M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 24th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 20 1914, to Feby 24 1914 that I last saw h was alive on Feby 24 1914, and that death occurred on the date stated above, at 8.30 P. M.

The CAUSE OF DEATH* was as follows:
Infantile Jaundice, (Icterus)

(Duration) ..... yrs. 1 mos. 4 ds.
Contributory (Secondary): Prenatal injury
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) O O Hall M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place none In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was Disease contracted,
If not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary — DATE OF BURIAL: Feby 25 1914

20. UNDERTAKER: F L Ayers — ADDRESS: Star Idaho

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 20

Primary Registration District No. 1011

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7274

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. D. Perkins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 20 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. L. Mowry

(Address) Wallace, Ida.

15. Filed Mch 2 1914 H. Leo Temple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 23 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1913 to Feb 23 1914, that I last saw h[illegible] alive on Feb 23 1914, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows: Cirrhosis of Liver

(Duration) Two Yrs. mos. ds.

Contributory (Secondary) Alcoholism

(Duration) yrs. mos. ds.

(Signed) W. L. Mowry M. D.

Mch 2 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace

DATE OF BURIAL: March 2 1914

20. UNDERTAKER: Woods Undertaking Co

ADDRESS

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello. (No. Bench St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
File No. 37275
Registered No. 137
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen O'Keen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: March (Month) 1 (Day) 1906 (Year)

7. AGE: 7 yrs. 11 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fort Collins Ida.

10. NAME OF FATHER: Christian O'Keen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Irene Bishop

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Bishop
(Address) Fort Collins

15. Filed Feb 13th 1914 O. Pickett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1914, to Feby 13 1914, that I last saw her alive on Feby 13 1914 and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis and Dilitation of Heart

(Duration) — yrs. — mos. 3 ds.
Contributory (Secondary) Scarlet Fever
(Duration) yrs. mos. 2 wks

(Signed) James F. Millen M. D.
2/14/1914 (Address) Fort Collins Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort Collins Ida | DATE OF BURIAL: Feby 14 1914

20. UNDERTAKER: W. M. Parker ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

15

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9"6
Primary Registration District No. 2
(No. 635 So Grant St.)

File No. 37276
Registered No. 132
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Shaver.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Jany. (Month) 11 (Day) 1914 (Year)

7. AGE
— yrs. — mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None.
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pocatello

10. NAME OF FATHER N. G. Shaver.

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Rosa Mason

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. G. Shaver
(Address) Pocatello

15.
Filed July 5 1914 O. B. Seaver
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feby 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1914, to Feby 5 1914, that I last saw him alive on Feby 5 1914, and that death occurred on the date stated above, at 3. a. M.

The CAUSE OF DEATH* was as follows:
Congenital Malformations / tuberculosis

(Duration) ... yrs. ... mos. 25 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. J. Howard M. D.
2/5 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mt View Cemetery | DATE OF BURIAL Feby 6 1914

20. UNDERTAKER H. D. Walker | ADDRESS Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Dr Wright

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Gen. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22
Primary Registration District No. 2161
File No. 7277
Registered No. 183

2. FULL NAME George Harris Spiros
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 23 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Sparta, Greece

10. NAME OF FATHER: Geo Spiros

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. Wright
(Address) Pocatello Ida

15. Filed Feby 8th 1914 O B Steadman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb 7th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31st 1914, to Feb 7th 1914, that I last saw him alive on Feb 7th 1914, and that death occurred on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration) Unknown yrs. mos. ds.

(Signed) W. D. Wright M. D.
2/12 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: Feb 11 1914

20. UNDERTAKER: Crawford and Schumacher ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock — Registration District No. 84
City of Pocatello — Primary Registration District No. 2161
(No. 345 E. No Arthur St.) — File No. 72783
If death occurs away from usual residence, give facts called for under special information. — Registered No. 134
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Liza Lacy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1894 (Year)

7. AGE: 19 yrs. 3 mos. 10 ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan Iowa Ida.

10. NAME OF FATHER: Wm. K. Edwards

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Susan Cunningham

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence Lacy
(Address) Pocatello Ida.

15. Filed Feby 9 1914 — O F Neely, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1913, to Feby 8 1914, that I last saw her alive on Feby 8 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A P Queen M. D.
Feby 19 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? —
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Woodville Idaho — DATE OF BURIAL: Feby 13 1914

20. UNDERTAKER: T. Brady — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 37280
Registered No. 136

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. Ranch St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb 15 (Month) (Day) 1857 (Year)

7. AGE: 57 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Charles Smith

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Jane Smith

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Smith
(Address) Portneuf Ida

15. Filed July 10th 1914 O B Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw him alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O B Steed M. D.
7-10-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery | DATE OF BURIAL: 7/19 1914

20. UNDERTAKER: Mt View Mortuary | ADDRESS: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. County Hospital St.)

File No. 3 7281
Registered No. 138
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Theulis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH
..... (Month) ..... (Day) ..... 1 (Year)

7. AGE about 50 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

No information

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. B. Walker
(Address) Pocatello Ida

15. Filed Feb 14 1914 H. Deeley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feby (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1914, to Feb 14 1914, that I last saw h.im alive on Feb 14 1914, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of bladder

..... (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. M. Newton M. D.
..... 19 ..... (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cemetery	2/16 1914

20. UNDERTAKER P. B. Walker ADDRESS Pocatello Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 7282
Registered No. 139

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 355, N. 7 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Beatrice Swift Garbett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: May (Month) 16 (Day) 1870 (Year)

7. AGE: 43 yrs. 10 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Alfred Swift

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah M. Barton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. Garbett
(Address) Pocatello Idaho

15. Filed July 18, 1914 O. B. Leach Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 1914, to Feby 16 1914, that I last saw her alive on Feby 16 1914, and that death occurred on the date stated above, at 8 10 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. mos. ds.

Contributory (Secondary) Myocarditis

(Duration) yrs. mos. ds.

(Signed) John W. Dawley M. D.
May 6 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: Feby 21 1914

20. UNDERTAKER: P. D. Walker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

3YMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3723
Registered No. 146

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 241 E. Center St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 1241

2. FULL NAME Roy McCabe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 64 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Walker
(Address) Pocatello Ida

15. Filed Feby 23, 1914 O. B. Seely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw him alive on Feby 21 1914,
and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) 1-2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr A M. Nurton M. D.
March 2 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 6 mos. 20 ds. In the State ..... yrs. 6 mos. 20 ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 2/25 1914

20. UNDERTAKER: W. M. Walker — ADDRESS: Pocatello Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 3 7284

Registered No. 141

County of Bannock

City of Pocatello (No. 230 N. Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Pipkin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 15th 1886 (Month) (Day) (Year)

7. AGE: 27 yrs. 6 mos. 9 ds.

IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: John Bishop

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Adda Stanley

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Clara Timms
(Address) 617 N. Garfield

15. Filed Feb 27, 1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 24th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22nd 1914, to Feb 24th 1914, that I last saw her alive on Feb 24th 1914 and that death occurred on the date stated above, at 6.50 A.M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary): Following parturition

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) W. A. Wright M. D.

2/24 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Feb 28 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 7285
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosa Fix

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: June (Month) 2 (Day) 1912 (Year)

7. AGE: 1 yrs. 8 mos. 23 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Joseph Fix

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Rosa B. Mergo

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Fix
(Address) Twin Falls

15. Filed 2-26 1914 John T. Coughlen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 1914, to Feb. 25 1914, that I last saw h was alive on Feb. 24 1914, and that death occurred on the date stated above, at 7:30 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory Measles
(Secondary)
(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) J. R. Morgan M. D.
Feb 26 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 2/26 1914

20. UNDERTAKER: Iff Grossman — ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 87
Primary Registration District No. 1085

File No. 7286
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza M. Dowdell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Wd

6. DATE OF BIRTH
May (Month) ..... (Day) 1869 (Year)

7. AGE
44 yrs. 8 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER John Olson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. J. Dowdell
(Address) R.F.D. Twin Falls

15.
Filed 2-24 191[illegible] John W. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. 22 191[illegible]
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found dead in bed. Afflicted for years with Chronic Heart disease
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas J. Crosby Coroner M. D.
19.... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 2/25 191[illegible]

20. UNDERTAKER: C J Crosby
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

File No. 7287

County of .....

City of ..... (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evelyn Bayliss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wife

6. DATE OF BIRTH: Apr. 3 (Month) (Day) 1871 (Year)

7. AGE: 41 yrs. 10 mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John E. Bayliss
(Address) 193 Cleveland Ave. Twin Falls Ida

15.
Filed 2-14 1914
John W. Brighton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 13 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1913, to Feb 13th 1914, that I last saw her alive on Feb 13th 1914, and that death occurred on the date stated above, at 11 10 P.M.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

(Duration) 6 or 8 yrs. mos. ds.

Contributory (Secondary) Myocarditis & Fatty Degeneration of Heart

(Duration) yrs. mos. ds.

(Signed) W. E. Rk M. D.

2/16/1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: Feb 15 1914

20. UNDERTAKER: Chas J. Cooley — ADDRESS: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 7288
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theodor Tweed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 12 (Day) 1886 (Year)

7. AGE: 28 yrs. 2 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: John Tweed

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Ellen Jones

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Reed
(Address) Jerome Ida

15. Filed 2-13 1914 John A Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9 1914, to Feb. 11 1914, that I last saw h[illegible] alive on Feb. 11 1914, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Hemorrhage & Shock following compound fracture of leg.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Wilson M. D.
Feb 13 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome — DATE OF BURIAL: 2/14 1914

20. UNDERTAKER: H. J. Grossman — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

File No. 7289

County of Twin Falls

City of Twin Falls (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Hulse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Boy	White	

6. DATE OF BIRTH: June (Month) 18 (Day) 1913 (Year)

7. AGE: ..... yrs. 7 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bent Co Colo

10. NAME OF FATHER Lewis J Hulse

11. BIRTHPLACE OF FATHER (State or Country) Marshal Co Iowa

12. MAIDEN NAME OF MOTHER Lula Bashor

13. BIRTHPLACE OF MOTHER (State or Country) Larmie Co Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Lewis J Hulse
(Address) Twin Falls

15. Filed 2-11 191[illegible] John T Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/8/1914, to 2/11/1914, that I last saw him alive on 2/11/1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Probably Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Measles

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) C D Mearns M. D.

2/12/1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Twin Falls	Feb 12 1914

20. UNDERTAKER	ADDRESS
C J Crosby	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 7290
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Mary Graham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Wid

6. DATE OF BIRTH
..... 1
(Month) (Day) (Year)

7. AGE
50 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Wm Gardner

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Agnes Gardner

13. BIRTHPLACE OF MOTHER (State or Country) Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Fawsett
(Address) Filer Idaho

15.
Filed 2-4 1914 Johnst Coghlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. 2 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1914, to Feb. 2 1914, that I last saw her alive on Feb 2 1914 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Pernicious Vomiting Secondary to rupture of Common Duct & Small bowel by large stone which become impacted in bowel 3" below
..... (Duration) ..... yrs. ..... mos. 7 ds.
Contributory Gall Stone Colic
(Secondary)
..... (Duration) 3 yrs. ..... mos. ..... ds.
(Signed) J. R. Morgan M. D.
Feb. 5 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 2-5 1914

20. UNDERTAKER: C. J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wardner (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 1201

File No. 27291
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Henry Florence Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 9 (Month) 12 (Day) 1860 (Year)

7. AGE: 53 yrs. 5 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canal Dover Ohio

10. NAME OF FATHER: Philip Henry Miller

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Rebekah Hykyle

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. O. Miller
(Address) Kellogg Idaho

15.
Filed Feb 18 1914 Geo. A. Leahy.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw him alive on ~~February~~ 1914,
and that death occurred on the date stated above, at 9.30 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary
Hemorrhage
.....
(Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Not signed but as transpired M. D.
19... (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canal Dover, Ohio
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Bruce G. Hartsell
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 123
County of Shoshone Primary Registration District No. 2 2 e 1
City of Kellogg (No. ..... St.) File No. 4 7292
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Mary Wendt Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Sept. (Month) 28 (Day) 1865 (Year)

7. AGE: 48 yrs. 4 mos. 28 ds. IF LESS than 1 day how many ..... hrs. ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Mr. Friesen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August Wendt
(Address) Kellogg Idaho

15.
Filed Feb. 28 1914 Geo. L Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1914 (Year),

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to 2/26 1914
that I last saw her alive on 2/26 1914,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Consumption.
She had no Doctor.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Mason. Health Officer M. D.
19..... (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenwood - Kellogg — DATE OF BURIAL: Mar. 1 1914

20. UNDERTAKER: E B Shanklin — ADDRESS: Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Mason

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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wardner
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201
(No. ..... , ... St.)

File No. 5 7293
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Phyllis Tonkin Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Aug (Month) 25 (Day) 1887 (Year)

7. AGE: 31 yrs. 5 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Joe Barnett

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Anne Dawe

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Feb 7th 1914 Geo. L Leahey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 24th 1914, to Feb 4 1914, that I last saw h~~er~~ alive on Feb 4 1914 and that death occurred on the date stated above, at 2:30 A M.

The CAUSE OF DEATH* was as follows:

Septic Infection.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Mason M. D.
2/2 7 1914 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenwood - Kellogg | DATE OF BURIAL: Feb 7 1914

20. UNDERTAKER: E B Thornhill | ADDRESS: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Bonner

Primary Registration District No. 215-6.

File No. 7295

City of Bonner Ferry (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Margaret Banning

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 25th (Day) 1834 (Year)

7. AGE: 79 yrs. 1 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Onida N. Y.

10. NAME OF FATHER: Russell

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Dunlop.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph K Banning
(Address) Bonner Ferry Ida

15. Filed Feb. 5th 1914 E. E. Fn. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21st 1914, to Feb. 5th 1914, that I last saw her alive on Feb. 5th 1914 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Cerebral hoemmorhage -

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Bronchitis

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) E E Fn - M. D.

Feb. 5 1914 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida | DATE OF BURIAL: 7th 191..

20. UNDERTAKER: John T. Moore | ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Boundary

Primary Registration District No. 2156

File No. 7296

City of Bonners Ferry (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Lee Doo

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	Yellow.	Married

6. DATE OF BIRTH

July 11th 1911
(Month) (Day) (Year)

7. AGE

2 yrs. 6 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Boundary Country Idaho

10. NAME OF FATHER Lee Doo

11. BIRTHPLACE OF FATHER (State or Country) China

12. MAIDEN NAME OF MOTHER Tong Moy

13. BIRTHPLACE OF MOTHER (State or Country) China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Doo

(Address) Bonners Ferry Ida

15.

Filed Feb. 7th. 1914 E E Fox
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 6 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1914, to Jan 31 1914, that I last saw her alive on Jan 31 1914, and that death occurred on the date stated above, at ~~not known~~ M.

The CAUSE OF DEATH* was as follows:

Diarrhoea and enteritis (2½ yrs 2 age)

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Stauffer M. D.

May 14 1914 (Address) Bonners Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	2/7 1914

20. UNDERTAKER	ADDRESS
John T. Modra	Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7297
Registered No.

1. PLACE OF DEATH.
Registration District No. 79
Primary Registration District No. 2156
County of Bonner
City of Bonners Ferry Ida (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Wall
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1835 (Year)

7. AGE 82 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER John Wall

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Malinda Routh

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry V. Wall
(Address) Los Angeles California

15.
Filed Feb. 11th 1914 E E Fry
Local ~~Registrar~~

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February (Month) 10th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31 st 1913, to Feb. 10th 1914, that I last saw h im alive on Feb. 9th 1914, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Senility
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Ulcer of leg.
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
Feb. 11 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Bonners Ferry Ida | DATE OF BURIAL 2/12 1914

20. UNDERTAKER John T. Moore | ADDRESS Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 2156
File No. 7298
Registered No.

1. PLACE OF DEATH.
County of Bonner
City of Bonners Ferry (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Violet Irene Emerson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1914 (Year)

7. AGE: ... yrs. ... mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bonners Ferry Ida

10. NAME OF FATHER: H B Emerson

11. BIRTHPLACE OF FATHER (State or Country): Fadudale Mass

12. MAIDEN NAME OF MOTHER: Tressie Mayers

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) H B Emerson
Bonners Ferry Idaho

15. Filed Feb. 12 th. 1914 E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 11 th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5 th. 1914, to Feb. 11 th. 1914, that I last saw her alive on Feb. 10 th. 1914, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ... yrs. ... mos. 4 ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) E E Fry M. D.
Feb. 11 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida
DATE OF BURIAL: ... 1914

20. UNDERTAKER: .....
ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M,1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 2156

File No. 7299

County of Bonner

City of Bonners Ferry (or Twp.), (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary L. Greening

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	White	

6. DATE OF BIRTH: June (Month) 17th (Day) 1913 (Year)

7. AGE: ..... yrs. 9 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bonners Ferry Ida

10. NAME OF FATHER William Greening.

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary McGinnis

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Greening
(Address) Bonners Ferry Ida

15.
Filed Feb. 16th. 1914 E.E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2nd. 1914, to Feb. 16th 1914, that I last saw her alive on Feb 15th 1914, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) Marasmus

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E.E. Fry M. D.

Feb. 17 1914 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry | DATE OF BURIAL: ..... 191..

20. UNDERTAKER | ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 79
County of Bonner
Primary Registration District No. 2156
File No. 7309
City of Bonners Ferry (No. ..... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ethel Marie James

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: March (Month) 6th (Day) 1904 (Year)

7. AGE: 9 yrs. 11 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bonners Ferry Ida

10. NAME OF FATHER Walter T. James

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Kate B. Hubble

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter T. James
(Address) Bonners Ferry Ida

15.
Filed Feb. 18th 1914. E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191[illegible], to Feb. 18 – 1914, that I last saw her alive on Feb. 17 – 1914 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Chronic valvular disease
(mitral insufficiency

(Duration) 3 yrs. ..... mos. ..... ds.
Contributory (Secondary) nephritis

(Duration) ..... yrs. 4 mos. ..... ds.

(Signed) E E Fry M. D.
2/19 1914 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 2/19 1914

20. UNDERTAKER: John T. Moore — ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

File No. 7301

County of Boundary

City of Bonners Ferry (Ida., St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Hanson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January (Month) 16th (Day) 1868 (Year)

7. AGE: 46 yrs. 1 mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Martin Hanson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Lary Hanson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Hanson

(Address) Bonners Ferry Idaho

15.

Filed Feb. 19th 1914 E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 19th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18th 1914, to ——— 191-, that I last saw h[im] alive on Feb. 18th 1914 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

2/19 1914 (Address) Bonners Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Chesapeake Falls Wis

DATE OF BURIAL 191-

20. UNDERTAKER: John T. Moore

ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of ..... (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2046

File No. 7302
Registered No. 17
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lester Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE:
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.):

6. DATE OF BIRTH
3 (Month) 11 (Day) 9 (Year) 1913

7. AGE
..... yrs. 3 mos. 11 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bannock Co

10. NAME OF FATHER John H. Taylor

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Maggie Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H Taylor
(Address) Downey

15.
Filed March 10 1914 Elvis Kaley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 7 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1914, to March 8 1914, that I last saw him alive on March 5 1914, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

..... (Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mink Center — DATE OF BURIAL: March 23 1914

20. UNDERTAKER: C E Taylor — ADDRESS: Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7303

Registered No. 21

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

County of Bannock

City of Chesterfield (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alzina Loveland Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1878 (Year)

7. AGE: 36 yrs. ..... mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: — wife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Heber C. Loveland

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Columbia F. Paul

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Israel E. Thompson
(Address) Chesterfield Ida

15.
Filed Mch 19 1914 Eric Kaeley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1914, to Mar 4 1914, that I last saw her alive on Feb 25 1914, and that death occurred on the date stated above, at 5a. M.

The CAUSE OF DEATH* was as follows:

Uremia

..... (Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) Acute Parenchymatous Nephritis

..... (Duration) ..... yrs. ..... mos. 12 ds.

(Signed) A. J. Smith M. D.

Mch 8 1914 (Address) Downey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Chesterfield — DATE OF BURIAL: Mch 6 1914

20. UNDERTAKER: Kerr Johnson — ADDRESS: Banks

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Downey
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2046
(No. ....., ... St.)

File No. 7304
Registered No. 18
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wallace Edgar Aldor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
Oct (Month) 6 (Day) 1913 (Year)

7. AGE
..... yrs. 5 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bannock Co

10. NAME OF FATHER Sidney E Aldor

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Alice E Aldor

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sidney E Aldor
(Address) Downey

15.
Filed Mch 16, 1914 Eris Kaley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1914, to March 6 1914
that I last saw him alive on March 6 1914,
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Casper Lauch M. D.
1914 (Address) Downey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge
DATE OF BURIAL: Mar 8 1914

20. UNDERTAKER: C. E. Layton
ADDRESS: Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2046
(No. ....., ... St.)

File No. 7305
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Olive Amy Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1912 (Year)

7. AGE: 1 yrs. 6 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chancy Bennett

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Amey Jackman

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chancy Bennett
(Address) Virginia Idaho

15. Filed March 16, 1914 Ellis Kaysey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6th 1914, to March 9 1914, that I last saw h[illegible] alive on 9 1914 and that death occurred on the date stated above, at 1 p M.

The CAUSE OF DEATH* was as follows:

Septicemia

..... (Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) Convulsions

..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Carlton Tanner M. D.

1914 (Address) Downey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cambridge	191...

20. UNDERTAKER	ADDRESS
C E Layton	Downey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Downey
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2046
(No. ....., ... St.)

File No. 7306
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold Laurence Russel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: 7 (Month) 24 (Day) 1913 (Year)

7. AGE: ..... yrs. 7 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Downey

10. NAME OF FATHER John William Russell

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Rodah Vanlaan

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Russell
(Address) Downey

15. Filed March 10, 1914 Ellis Kasey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1914, to March 6 1914, that I last saw him alive on March 6 1914 and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carbon Tucker M. D.
19 ..... (Address) Downey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge
DATE OF BURIAL: 8 Ch 1914

20. UNDERTAKER: C E Layton
ADDRESS: Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2146
File No. 730
Registered No. 3

1. PLACE OF DEATH.
County of Latah
City of Boveill (No. #, # St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Celip St. Germain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	White	Married

6. DATE OF BIRTH. Jan. (Month) - 22 (Day) - 1865 (Year)

7. AGE 49 Yrs. 2 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)... at home

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Alexander Mondeau

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mary Lerville

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. St Germain
(Address) Boveill Idaho.

15. Filed 3 / 30 / 1914 F C Gibson Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1914, to March 29 1914, that I last saw her alive on March 29 - 1914, and that death occured on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Cholangicitis

(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary) Carcinoma Liver & Pancreas
(Duration 1 yrs. 6 mos. - ds.

(Signed) F C Gibson M. D.
1914. (Address) Boveill Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State. 9 yrs. - mos. - days
Where was disease contracted if not at place of death? .....
Former or usual residence Boveill Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wisconsin	191

20. UNDERTAKER	ADDRESS
L. C. Shaw	Colfax, Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 8730
Registered No. 2

1. PLACE OF DEATH.
County of Latah
City of Bovill
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Not known (Month) (Day) 1 (Year)
7. AGE: 38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Potlatch Lumber Co
9. BIRTHPLACE (State or Country): Finland
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (State or Country): Not known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) None
(Address) None
15. Filed 3/5/1914 F C Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) – 5 (Day) – 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 28 – 1914, to March 5 – 1914, that I last saw him alive on March 5 / 1914, and that death occured on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Accidental Injury Skull Fracture
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs ..... mos. ..... ds.
(Signed) F C Gibson M. D.
3/9/1914 (Address) Bovill

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill — DATE OF BURIAL: 1914
20. UNDERTAKER: J. L. Champion — ADDRESS: Bovill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2 7309

Registered No. 1

1. PLACE OF DEATH.

County of Latah

City of Bovill

Registration District No. 66

Primary Registration District No. 2146

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Jane Bellows

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 2 (Month) - 9 (Day) - 1914 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harris Bellows

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Annette Kellow

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harris Bellows

(Address) Bovill Idaho

15. Filed 2/3/1914 F.C. Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) - 2 (Day) - 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 - 1914, to March 2 - 1914, that I last saw h[illegible] alive on March 2 - 1914, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(Duration) ..... Yrs. ..... mos. 1/2 ds.

Contributory (Secondary) Acute Bronchitis

(Duration ..... yrs. ..... mos. 2 ds.

(Signed) F.C. Gibson M. D.

1914 (Address) Bovill.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill Idaho

DATE OF BURIAL: 2/3 1914

20. UNDERTAKER: Shaw.

ADDRESS: Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of near Linden
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No.) St.)

File No. 7310
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irene Keeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH: 3 (Month) 4 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Linden Ida

10. NAME OF FATHER: Chas Keeler

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Millie Mann

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Keeler father
(Address) Linden Ida

15. Filed MCh 26 1914 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-25 1914, to 3-25 1914, that I last saw h W alive on 3-25 1914 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
weakness

(Duration) yrs. mos. ds.
Contributory (Secondary) Probably Pneumonia
(Duration) yrs. mos. ds.

(Signed) Dr Bussey M. D.
3-26 1914 (Address) Southwick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Linden Ida
DATE OF BURIAL: 3-27 1914

20. UNDERTAKER: None
ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 63
Primary Registration District No. 2143
File No. 7311
County of Latah
City of near Kendrick ((No. ..., ... St.)
Registered No. 5
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Lee R Carlton
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 18 (Day) 1851 (Year)

7. AGE: 64 yrs. 4 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo Davidson
(Address) Kendrick Idaho

15.
Filed Mch 9 1914 J E Hoyt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1914, to Mch 9 1914, that I last saw him alive on Mch 8 1914, and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Organic disease of Heart
(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Parenchymatous nephritis
(Duration) 2+ yrs. mos. ds.

(Signed) J. E. Hoyt M. D.
3-9 1914 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho
DATE OF BURIAL: Mch 10 1914

20. UNDERTAKER: Stevens
ADDRESS: Moscow Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2107
(No. ....., ... St.)

File No. 7315
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Natarou Arase

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. 21 (Month) (Day) 1 1914 (Year)

7. AGE: X yrs. X mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chief
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogden Utah

10. NAME OF FATHER: M Arase

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Shige Iwahashi

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L L Okimoto
(Address) Idaho Falls, Ida.

15. Filed Apr 3 191 4 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 2, 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191.., to — 191..., that I last saw h— alive on — 191..., and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis
Pulmonal
Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19.. (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 4/3 191 4

20. UNDERTAKER: C. E. Dinwoodey
ADDRESS: Ida Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7316

Registered No. 37

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Idaho Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2180

2. FULL NAME John Castle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March 13 (Month) (Day) 1842 (Year)

7. AGE: 71 yrs. 19 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Castle

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Kate Ralph

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Castle
(Address) Idaho Falls Idaho

15. Filed Apr 3 1914 C. E. Greenwood Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 31 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191.., to — 191.., that I last saw h.. alive on .. 191.., and that death occurred on the date stated above, at 1P. M.

The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. H. Coulthard M. D.

4/3 1914 (Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lyman Idaho — DATE OF BURIAL: 4/3 1914

20. UNDERTAKER: Linwood Dy Co. — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneville

Primary Registration District No. 21

City of Idaho Falls

(No. ....., ... St.)

File No. 7317

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Andreason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Dec 5th 1901 (Month) (Day) (Year)

7. AGE: 17 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Peter Andreason

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Holm

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Andreason

(Address) Idaho Falls,

15. Filed Mar 30 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Inf Lagulatory Rheumatism
When called boy was
dead. Above probable cause

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

3/30 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rest Sweden Cemetery | DATE OF BURIAL: Apr 1 1914

20. UNDERTAKER: Linwoodey Furn Co | ADDRESS: Idaho Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2 1 0
(No. , St.)

File No. 7318
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME August Roepke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: December 1st 1866 (Month) (Day) (Year)

7. AGE: 47 yrs. 3 mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Daniel Röepcke

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dorothea Prestera

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maria F. Röepcke
(Address) Idaho Falls, Ida

15.
Filed Mar 27 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. 14 - 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March-10 1914, to Mar. 14 1914, that I last saw h[illegible] alive on March - 14 1914, and that death occurred on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:
Locomotorataxia

(Duration) ✓ yrs. 8 mos. ds.
Contributory ✓
(Secondary)
(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) [signature] M. D.
19 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 3/27 1914

20. UNDERTAKER: Dinwoody F. Co
ADDRESS: Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2110
File No. 7315
Registered No. 29

1. PLACE OF DEATH.
County of Bingham
City of Idaho Falls, Idaho (No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vincent F. Connolly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: May (Month) 7th (Day) 1880 (Year)

7. AGE: 33 yrs. 10 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling Salesman
(b) General nature of industry business, or establishment in which employed (or employer): Steel Mine Goods

9. BIRTHPLACE (State or Country): Amboy Illinois

10. NAME OF FATHER: Peter Byron Connolly

11. BIRTHPLACE OF FATHER (State or Country): Armagh Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth B. Connolly

13. BIRTHPLACE OF MOTHER (State or Country): Cullyhanna Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Egbert V. Connolly
(Address) 1142 E. 46th St. Chicago Ill.

15. Filed Mar 27 1914 W. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913 to March 27 1914, that I last saw h[illegible] alive on March 27 1914, and that death occurred on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lungs

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Hemorrhage 10 Min.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. 3 days.

Where was disease contracted if not at place of death? Springfield Ills

Former or usual residence Salt Lake City Utah

19. PLACE OF BURIAL OR ~~REMOVAL~~: Amboy Illinois — DATE OF BURIAL: March 31 1914

20. UNDERTAKER: F. C. Vaughan — ADDRESS: Amboy, Ills

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Mtn Home
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020
(No. ....., ... St.)

File No. 7320
Registered No. 8
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Calvin Erwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
Mch (Month) 13 (Day) 1881 (Year)

7. AGE
33 yrs. — mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Labour
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER Wm Erwin

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Martha Pilcher

13. BIRTHPLACE OF MOTHER (State or Country) Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Brin by Mrs C Erwin
(Address) Mtn Home Id

15. Filed Mar. 18th 1914 W. W. Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mch (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 11 1914, to Mch 1917
that I last saw h is alive on Mch 17 1914,
and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. A. Crozier M. D.
3-16 1914 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home — DATE OF BURIAL: Mar. 19th 1914

20. UNDERTAKER: J. M. Cowen — ADDRESS: Mtn. Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 7321
Registered No. 4

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Naomi W. D. Phelps

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: January (Month) 6 (Day) 1844 (Year)

7. AGE: 70 yrs. 2 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Evangelist
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Idaho~~ Ohio

10. NAME OF FATHER: Duncan McDonald

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Rhoda Horne

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. R. Colthorp
(Address) Mora, Idaho,

15. Filed March 7 1914 Geo. Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: ~~Feb~~ March 9 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Feb~~ March 1 1914, to ~~Feb~~ March 9 1914, that I last saw her alive on March 7 1914, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Acute Bright's Disease

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Frazier M. D.
3/9 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Whitney Ranch Symp | DATE OF BURIAL: March 11 1914

20. UNDERTAKER: J. M. Cowen ADDRESS: Mountain Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 7322
Registered No.

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles A. Stevens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Nov 23 (Month) (Day) 1849 (Year)

7. AGE
65 yrs. 4 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER John B. Stevens

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Hannah Hoey

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur A. Stevens
(Address) Mt Home Ida.

15.
Filed April 1st 1914 Bu Mather Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 31st 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart
(sudden)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Bu Mather M. D.
3/31 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise City | DATE OF BURIAL ..... 191...

20. UNDERTAKER: J M Corwin | ADDRESS: Mountain Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 34

County of Elmore Primary Registration District No. 2020

City of Broad View (No. ....., ... St.)

File No. 7323

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Wilcox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Unknown (Month) 1 (Day) (Year)

7. AGE 60 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Elisha Wilcox

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Agnes Haygal

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. O. Myers

(Address) Mt. Home Ida.

15. Filed March 16th 1914 Chas Mather Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 16th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart

Sudden
(Duration) ..... yrs. — mos. — ds.

Contributory —
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Eaton Coro. ~~M. D.~~

3/16 1914 (Address) Mt. Home, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Boise City | DATE OF BURIAL ..... 191...

20. UNDERTAKER J. M. Corwin | ADDRESS Mountain Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7324

Registered No. 6

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 34

Primary Registration District No. 20 20

County of Elmore

City of Mountainhome (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte Winter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: January (Month) 12 (Day) 1838 (Year)

7. AGE: 76 yrs. 3 mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Oneill

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Chorlott Oneill

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John D Winter
(Address) Mountain Home

15. Filed March 24th 1914 B W Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1914, to March 24 1914, that I last saw her alive on March 24 1914 and that death occurred on the date stated above, at 5 30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W L Trayis M. D.

3/24 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountainhome | DATE OF BURIAL: Mar 25 1914

20. UNDERTAKER: J M Owen | ADDRESS: Mountainhome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 7325
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME S. de Groat

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Nov (Month) 28 (Day) 1830 (Year)

7. AGE: 84 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Old Stage driver
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Cauley
(Address) Grangeville Ida

15.
Filed Mch 31 1914 — G. B. Stockton, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Suicide by fire arms

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G S Stockton M. D.
Feb 3 1914 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Prairie View, Grangeville	Feb 3 1914

20. UNDERTAKER	ADDRESS
E. S. Hancock	Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 7326
Registered No. 5

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Homer Shinkle
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 9 1889 (Month) (Day) (Year)

7. AGE: 25 yrs. — mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bolder Co. Colo

10. NAME OF FATHER: Richard F Shinkle

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Effie F Moody

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Agnes F Mays
(Address) Grangeville Idaho

15. Filed March 26 1914 G S Stricklin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 14 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1914 to March 14 1914 that I last saw him alive on March 13 1914 and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Post operative paralysis of bowels

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stricklin M. D.

Mch 14 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: Mch 15 1914

20. UNDERTAKER: W E Graham | ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7327
Registered No. 4

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Root

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widowed
6. DATE OF BIRTH: don't know (Month) 1 (Day) ..... (Year)
7. AGE: about 84 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): Inmate County Farm
9. BIRTHPLACE (State or Country): [illegible]
10. NAME OF FATHER: [illegible]
11. BIRTHPLACE OF FATHER (State or Country): [illegible]
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (State or Country): [illegible]
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Byers
(Address) County Poor Farm Grangeville Ida
15. Filed March 26 1914 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 13 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 8 1914, to March 13 1914
that I last saw h[illegible] alive on Mch 8 1914
and that death occurred on the date stated above, at 11a M.
The CAUSE OF DEATH* was as follows:
Senile Decay
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. B. Stockton M. D.
Mch 13 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Mch 14 1914
20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 9196

(No. ....., ... St.)

File No. 7328

Registered No. 20

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Earl Walters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH

Aug. (Month) 21 (Day) 1907 (Year)

7. AGE

7 yrs. 6 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... At home

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Fremont Co Ida

10. NAME OF FATHER Daniel Walters

11. BIRTHPLACE OF FATHER (State or Country) Cache Co Utah

12. MAIDEN NAME OF MOTHER Mary L. Otts

13. BIRTHPLACE OF MOTHER (State or Country) Boulder Co Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dan Walters

(Address) Burley Idaho

15.

Filed 3-16-14 191.. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1914, to March 15 1914, that I last saw h.. alive on March 15 1914, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

2 Am

Pneumonia

Bronchial

(Duration) ..... yrs. ..... mos. 12 ds.

Contributory .....

(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Muster M. D.

March 19 14 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Mar. 18 1914

20. UNDERTAKER: L. B. Gallagly — ADDRESS: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & RDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7328

Name Danial Earl Walters

Date of Death Mar. 15. 1914

Cause of Death Broncho Pneumonia

Contributary Cause of death

(Sign here) John M. Mueller M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 7329
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis Heath Cavaness

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 19 (Day) 1853 (Year)

7. AGE: 60 yrs. 4 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lodging House Keeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Warren Co Tenn

10. NAME OF FATHER: Jerry B. Cavaness

11. BIRTHPLACE OF FATHER (State or Country): Warren Co Tenn

12. MAIDEN NAME OF MOTHER: Kisiah Huckby

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S E Cavaness
(Address) Burley Idaho

15. Filed 4-22-'14 191... Dr. J.C Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 21st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1913., to March 21st 1914, that I last saw h-- alive on March 21st 1914, and that death occurred on the date stated above, at 4 a.m. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
3-21 1914 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Burley, Ida. | DATE OF BURIAL: 3-21 1914

20. UNDERTAKER: L. B. Gallegly | ADDRESS: Burley, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 7330
Registered No. 18

1. PLACE OF DEATH.
County of Bear Lake
City of Kemport (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Esther Pratt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1876 (Year)

7. AGE: 38 yrs. 4 mos. 11 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Tencum Pratt

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake Co. Ut

12. MAIDEN NAME OF MOTHER: Anna L Mead

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake Co. Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie E. Pratt
(Address) Salt Lake City Utah

15.
Filed 3-23-14 191... Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 22nd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1913, to March 22 1914, that I last saw h... alive on ...191..., and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) ...yrs. ...mos. ...ds.

Contributory (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) L. B. Gallagly, Coroner M. D.
Mar 23 1914 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah
DATE OF BURIAL: Mar 24 1914

20. UNDERTAKER: L. B. Gallagly
ADDRESS: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 7331
Registered No. 21

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy Ann Congleton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Feb. (Month) 15 (Day) 1839 (Year)

7. AGE: 75 yrs. 1 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Formerly a School teacher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash Co. Ohio

10. NAME OF FATHER: Wm Otis

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Sabrina Rice

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E B M Congleton
(Address) Burley Idaho.

15.
Filed 3-15-14 191 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 7 1914, to Mch 14 1914, that I last saw her alive on Mch 14 1914, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows: Capillary Bronchitis

(Duration) ..... yrs. mos. 12 ds.
Contributory (Secondary) Chronic Bronchitis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Winton M. D.
Mch 13 1914 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Mar 16 1914

20. UNDERTAKER: L D Gallogly — ADDRESS: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

File No. 7332

City of Burley

(No. ....., ... St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Inez Gochnour

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Feb. (Month) 7 (Day) 1913 (Year)

7. AGE

1 yrs. 1 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... At home

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Burley Cassia Co Ida

10. NAME OF FATHER

John B. Gochnour

11. BIRTHPLACE OF FATHER

(State or Country) Bedford Penn.

12. MAIDEN NAME OF MOTHER

Edna Cessna

13. BIRTHPLACE OF MOTHER

(State or Country) Bedford Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C B Gochnour

(Address) Burley Idaho

15.

Filed 4-1-14 191 Dr. J. E. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1914, to March 30 1914, that I last saw her alive on March 29 1914, and that death occurred on the date stated above, at 9A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Whooping Cough

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John M Muter M. D.

Mch 31 1914 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Ida	March 31 1914
20. UNDERTAKER	**ADDRESS**
L D Talbot	Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

File No. 7333

City of Burley (No. ....., ... St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Dyce Youmans

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 17 (Day) 1888 (Year)

7. AGE: 26 yrs. 10 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Caldwell Kansas

10. NAME OF FATHER: William W. Youmans

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Hettie Lane

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W W Youmans
(Address) Burley Idaho

15.
Filed 4-1-14 191 ..... Reg. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L B Galloghy Coroner M. D.

March 31 1914 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Ida.	March 31 1914
20. UNDERTAKER	ADDRESS
L B Galloghy	Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7334
Registered No.

1. PLACE OF DEATH.
County of Nezperce
City of Melrose
Registration District No. 92
Primary Registration District No. 7170
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Electus M. Frost

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: June (Month) 22 (Day) 1841 (Year)

7. AGE: 72 yrs. 8 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pensilvania

10. NAME OF FATHER: John M. Frost

11. BIRTHPLACE OF FATHER (State or Country): York State

12. MAIDEN NAME OF MOTHER: Mary Kibsey

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred M. Frost
(Address) Gifford Ida.

15. Filed 3-5 1914 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 3rd (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21st 1913, to March 3rd 1914
that I last saw him alive on Feby 28th 1914
and that death occurred on the date stated above, at 2.30 M.

The CAUSE OF DEATH* was as follows:
Valvular Insufficiency.
..... (Duration) ..... yrs. 8 mos. 1 ds.
Contributory (Secondary) Enlargement of Liver
..... (Duration) ..... yrs. 4 mos. 6 ds.

(Signed) J. J. Pennington M. D.
3-5-th 1914 (Address) Gifford Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melrose
DATE OF BURIAL: 3-6 1914

20. UNDERTAKER: J. W. Hall
ADDRESS: Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7335
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Kamiah

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby George

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: March (Month) 10th (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. a few hours
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kamiah

10. NAME OF FATHER: Milton George

11. BIRTHPLACE OF FATHER (State or Country): Miles

12. MAIDEN NAME OF MOTHER: Nattie Axtell

13. BIRTHPLACE OF MOTHER (State or Country): Kamiah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stephen Axtell
(Address) Kamiah Idaho

15. Filed 3/10 1914 W. H. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at 4 AM.
The CAUSE OF DEATH* was as follows:
No Physician in attendance
lived only a few minutes.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Cemetery No 1
DATE OF BURIAL: Mar 11th 1914

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7336
Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
(No. ..... St.)

Registration District No. 49
Primary Registration District No. 2128

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nehemiah E. Parsons

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Indian	Married

6. DATE OF BIRTH
— (Month) — (Day) 1 (Year)

7. AGE
90 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kamiah

10. NAME OF FATHER Eugene Malliken

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Parsons
(Address) Kamiah Ida.

15.
Filed 3/16 1914 W. J. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
3 (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/6 1914, to same 1914 that I last saw h[illegible] alive on same 1914 and that death occurred on the date stated above, at 7:00 AM.

The CAUSE OF DEATH* was as follows:
Pneumonia
Influenza

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. McMahan M. D.
3/9 1914 (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Cemetery No 2
DATE OF BURIAL: Mar 10th 1914

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7336

Name Nehemiah F. Parsons

Date of Death Mar. 9, 1914

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) W. F. McMahan M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7337
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Woodland

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucinda Pool Lansing

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept. (Month) 27th (Day) 1852 (Year)

7. AGE: 61 yrs. 6 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Knox Co. Ill.

10. NAME OF FATHER: Thomas H Pool

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Nancy McMurtry

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O J Lansing
(Address) Woodland Idaho

15. Filed 4/8 1914 W. F. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16th 1913, to April 6th 1914
that I last saw her alive on April 4th 1914
and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:
Amyotrophic Lateral Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Bryan M. D.
4/7 1914 (Address) Ramah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodland
DATE OF BURIAL: April 6 1914

20. UNDERTAKER: E. F. Brown
ADDRESS: Ramah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7335
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Kamiah (No. ....., ... St.)

Registration District No. 49
Primary Registration District No. 2128

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Grant.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	Indian	single

6. DATE OF BIRTH: July (Month) 25 (Day) 1910 (Year)

7. AGE: 3 yrs. 9 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: That of a child.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho County

10. NAME OF FATHER: Abel J. Grant

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lizzie Hayes.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lizzie H. Grant.
(Address) .....

15. Filed 4/8 1914 W. T. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26 1914, to June 1914 that I last saw h[er] alive on 3/25 1914 and that death occurred on the date stated above, at 7:4 M.

The CAUSE OF DEATH,* was as follows:
Pleuritis Pulmonalis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. McMahan M. D.
4/6 1914 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian cemetery at Kamiah — DATE OF BURIAL: April 7 1914

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7339
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Kamiah
Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1847 (Year)

7. AGE: 67 yrs. 1 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Ole Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Johnson
(Address) Woodrow Idaho

15. Filed 3/23 1914 W. F. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/13 1914, to same 1914
that I last saw her alive on 3/13 1914
and that death occurred on the date stated above, at 5:10 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. F. McMahan M. D.
3/14 1914 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Willow Hill Cemetery
DATE OF BURIAL: Mar. 16 1914

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

1. PLACE OF DEATH. Registration District No. 2610 Bureau of Vital Statistics
County of Canyon Primary Registration District No. 1010 File No. 7341
City of Emmett (No. ....., ... St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Phoebe Womack
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1840 (Year)

7. AGE: 70 yrs. — mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. W. Perkins

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Matilda Galland

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex Womack
(Address) Emmett Idaho

15. Filed 3 22 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 4th (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1913, to Mar 4 191[illegible]
that I last saw h[illegible] alive on Mar 4 191[illegible]
and that death occurred on the date stated above, at 11 30 A M
The CAUSE OF DEATH* was as follows:
Mitral Stenosis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Pleumalasm
..... (Duration) 20 yrs. ..... mos. ..... ds.
(Signed) B. O. Hall M. D.
Mar 5 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: Mar. 5 191[illegible]

20. UNDERTAKER: C. L. Buckner
ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No.
(No. , St.)
File No. 7342
Registered No.

1. PLACE OF DEATH.
County of Minedoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ely H Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): M

6. DATE OF BIRTH. Sept (Month) 4 (Day) 1858 (Year)

7. AGE: 56 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Ely H Allen

11. BIRTHPLACE OF FATHER (State or Country) Californian

12. MAIDEN NAME OF MOTHER Mary Linn

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Allen
(Address) .....

15. Filed 3-22 1914
O H Lee
Local Registrar

BYRD - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 19th 1914, to Mar 22nd 1914, that I last saw h[illegible] alive on Mar 22 at 1914, and that death occured on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:
Uraemic Convulsions
several days
(Duration) Yrs. mos. ds.
Contributory (Secondary) Parenchymatous Nephritis
(Duration) do not know yrs. mos. ds.
(Signed) W. T. Rowley M. D.
19..... (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida — DATE OF BURIAL: Mar 23 1914

20. UNDERTAKER: W. O. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7343

Registered No. 23

1. PLACE OF DEATH.

County of Boise

City of Garden Valley

Registration District No. 12

Primary Registration District No. 2-012

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Scandlin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed.

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 79 yrs. about mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Apr 9 1914 May Fitz Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from never attended 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
unknown.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. G. Fitz M. D.

Apr 8 1914 (Address) Placerville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Placerville Idaho

DATE OF BURIAL: Mar 30 1914

20. UNDERTAKER: Had none.

ADDRESS

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7341
Registered No. 22

1. PLACE OF DEATH.
County of Boise
City of Idaho City
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2015
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Rebecca Tyson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH: Dec – 25 – 1833 (Month) (Day) (Year)
7. AGE: 87 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Virginia
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Tyson
(Address) Idaho City
15.
Filed Apr 8 1914 May Fitz Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar – 28 – 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from never attended at all. 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
unknown.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Fitz M. D.
Apr 8 1914 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho City
DATE OF BURIAL: Mar 29 1914
20. UNDERTAKER: Hadmore
ADDRESS:

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Adams

Primary Registration District No. 2011

City of Council (No. ....., ... St.)

File No. 7345

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo F Gregg

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Mar (Month) 15 (Day) 1856 (Year)

7. AGE

57 yrs. 12 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Steamboat

(b) General nature of industry business, or dstablishment in which employed (or employer) Merchant

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER Geo

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Sarah Robinson

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Geo F Gregg

(Address) Council

15.

Filed 3 - 5 - 1914 Frank V Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Mar 4 1914, that I last saw him alive on Mar 4 1914, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E. Brown M. D.

3-5 1914 (Address) Council, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Council	3 - 5 - 1914

20. UNDERTAKER	ADDRESS
Roy Young	Council

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Adams
City of N. Meadows (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 202

File No. 7347
Registered No. ...
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Owen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Chinaman	Single

6. DATE OF BIRTH ? ? 1849
(Month) (Day) (Year)

7. AGE 65 yrs. ... mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Placer Miner
(b) General nature of industry business, or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER Unascertained

11. BIRTHPLACE OF FATHER (State or Country) Unascertained

12. MAIDEN NAME OF MOTHER Unascertained

13. BIRTHPLACE OF MOTHER (State or Country) Unascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R L Whiteman M.D.
(Address) N. Meadows - Ida

15. Filed ... 191...
R L Whiteman
Local Registrar
By Jms

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 21 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 191..., to Mar. 21 1914, that I last saw him alive on Mar. 21 1914, and that death occurred on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver.
(Duration) 2 yrs. 0 mos. 0 ds.
Contributory (Secondary) Alcoholism
(Duration) ... yrs. ... mos. ... ds.
(Signed) R L Whiteman M. D.
19... (Address) N Meadows Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State 40 yrs. 2 mos. 0 days.
Where was disease contracted if not at place of death? ...
Former or usual residence Warrens - Idaho.

19. PLACE OF BURIAL OR REMOVAL Meadows Ida. DATE OF BURIAL 3/23 1914

20. UNDERTAKER None Employed. Buried by County. ADDRESS
Should be signed by undertaker D/B.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS - YORK CO., PTRS. & STRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 734
Registered No. 25

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charley W Roberts
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 15 (Day) 1897 (Year)

7. AGE: 16 yrs. 10 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Stephen Roberts

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mincy Agsbly

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L W Roberts
(Address) Troy Idah

15. Filed Mch 12 1914 J W Clarke Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1914, to March 11 1914, that I last saw him alive on March 11 1914, and that death occurred on the date stated above, at 3 M.

The CAUSE OF DEATH* was as follows:
Suppurative peritonitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.
19 ..... (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 3/12 1914

20. UNDERTAKER: Geo Stolz | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Deary
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ... St.)

File No. 1734
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Emil Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Aug. 22 1894 (Month) (Day) (Year)

7. AGE: 19 yrs. 7 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Ole Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Brita Pearson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nestor Olson
(Address) Deary

15. Filed Mar 24 1914 W. C. Faucher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 23 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
accidental explosion
dynamite
instantaneous

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cem | DATE OF BURIAL: Mar 25 1914

20. UNDERTAKER: J. E. Pickard | ADDRESS: Deary

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116

File No. 7350
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glen Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: December 23 (Month) (Day) 1896 (Year)

7. AGE: 17 yrs. 3 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouria

10. NAME OF FATHER: Joseph Shaw

11. BIRTHPLACE OF FATHER (State or Country): Missouria

12. MAIDEN NAME OF MOTHER: Neva Houston

13. BIRTHPLACE OF MOTHER (State or Country): Missouria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Joseph B. Shaw
(Address): Salmon Ida

15.
Filed March 26 1914 Helen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 26" (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1914, to March 26 1914
that I last saw h[illegible] alive on March 25 1914
and that death occurred on the date stated above, at 3.30 M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
(Duration) 3 4 yrs. ..... mos. ..... ds.
Contributory (Secondary) Scarlatina, 40 days
Chronic nephritis 28 days
(Duration) ..... yrs. ..... mos. 2 6 days

(Signed) Chas. F. Hammer M. D.
3-26 1914 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery | DATE OF BURIAL: 3-26 1914

20. UNDERTAKER: W. A. Doebler | ADDRESS: Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
(No. .... St.)

File No. 7351
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Parma
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. R. Custead

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 31 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: M. J. Custead

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. S. Clark
(Address) Parma Idaho

15. Filed Mar. 6 1914 Fabernick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased~~ from 191 ..., to ..... 191 ..., ~~that I last saw h~~ alive on ..... 191 ..., ~~and that death occured on the date stated above, at~~ ..... M.

The CAUSE OF DEATH* was as follows:
Suicide by Hanging
(Coroners Inquest)
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred K Robinson M. D.
3-5-1914 (Address) Nampa Ida Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meadville Parma
DATE OF BURIAL ..... 191 .....

20. UNDERTAKER: F K Robinson
ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7352
Registered No.

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2007
~~City of~~ 9 miles West of Wilder No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME James Madison Griggs
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 15 1850 (Month) (Day) (Year)

7. AGE: 63 yrs. 7 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Seneca Co New York.

10. NAME OF FATHER: Peter Griggs

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Unable to find her Maiden Name

13. BIRTHPLACE OF MOTHER (State or Country): Unable to Give She's

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Madison Griggs
(Address) Parma Ida

15.
Filed 3/19 1914 T. A. Schmidt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ From Jany 1st 1914, to March 9th 1914
that I last saw h... alive on March 9th 1914
and that death occurred on the date stated above, at 630 A. M.

The CAUSE OF DEATH* was as follows: Paralysis Of The Heart. - He has been Suffering from Paralysis 7 entire ~~Sides~~ Sides for 1 year. also Chronic Valvular Heart Disease (Duration) Heart trouble 10 years. yrs. mos. ds.

Contributory (Secondary) Paralysis 1 year Caused from excessive use of alcohol (Duration) 1 yrs. mos. ds.

(Signed) Harold Dawson M. D.
3/17 1914 (Address) Parma Ida R201

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Parma Ida — DATE OF BURIAL: 3/19 1914

20. UNDERTAKER: Black Packham Co — ADDRESS: Parma Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 2007

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4353

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

~~City~~ of Parma

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Feby 29 (Month) 1832 (Year)

7. AGE: 82 Yrs. # Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lady Ohio

10. NAME OF FATHER: P. Forbes

11. BIRTHPLACE OF FATHER (State or Country): (Pensylvania ?)

12. MAIDEN NAME OF MOTHER: — Jamieson

13. BIRTHPLACE OF MOTHER (State or Country): (Pensylvania ?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Allie Campbell Park
(Address) Parma Ida

15. Filed Mar. 8 1914 Fae Schmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1914, to March 1914, that I last saw her alive on March 5 1914, and that death occured on the date stated above, at 30 M.

The CAUSE OF DEATH* was as follows:
Senile debility
.....(Duration) — Yrs. 6 mos. — ds.
Contributory (Secondary) Chronic indigestion
.....(Duration — yrs. 6 mos. — ds.
(Signed) William R. Mulder M. D.
19..... (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? at place of death
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [redacted] Iowa | DATE OF BURIAL: — 191...

20. UNDERTAKER: F K Robinson | ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1
File No. 7351
Registered No. 16

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. ..., Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence A. Howard

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 23 (Day) 1912 (Year)

7. AGE: 1 yrs. 9 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grangeville, Ida.

10. NAME OF FATHER: L. M. Howard

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: L. Wood

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. T. Harris
(Address) Lewiston.

15.
Filed 4-10- 1914 S. J. Watkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2/1914 to 3/3/1914 that I last saw him alive on 3/3/1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Abscess of Kidney
(Duration) ... yrs. 6 mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) F. T. Harris, M. D.
3/3/1914 (Address) Lewiston

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 1 days. In the State 1 yrs. 9 mos. ... days.
Where was disease contracted if not at place of death? Grangeville
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grangeville Ida. | DATE OF BURIAL: Mar 4 1914

20. UNDERTAKER: Sarah | ADDRESS: Lewiston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1037
File No. 7355
Registered No. 17

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. C & E Sts. 1 St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jim Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	Chinaman	Single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE 76 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) " " "

12. MAIDEN NAME OF MOTHER " " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Larson
(Address) Lewiston

15.
Filed 4-10- 1914 R. P. Rees
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1914, to March 7 1914, that I last saw h in alive on March 7 1914, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Edema of Lungs

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Edwin G. Broaddus M. D.
Mar 7 1914 (Address) 1121 Idaho St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho | DATE OF BURIAL: Mar. 1914

20. UNDERTAKER: J. Larson | ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7356
Registered No. 18

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. 514, New 16th St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No. 1093

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grace H. Lind

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ~~40~~ Nov. (Month) 18 (Day) 1873 (Year)

7. AGE: 40 yrs. 3 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Jos. McCall

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sanborn

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. H. Lind
(Address) City

15. Filed 4-10-1914 S. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1914, to March 13 1914, that I last saw her alive on March 12 1914, and that death occurred on the date stated above, at 8-23 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) several years mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) S. J. Perkins M. D.
3/13 1914 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho
DATE OF BURIAL: 8-15-1914

20. UNDERTAKER: J. Hassar
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 7358
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Star Eagle

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Cole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Apr. 2 (Month) (Day) 1914 (Year)

7. AGE
— Yrs. — Mos. — ds.
IF LESS than 1 day how many ....hrs. or ....min.? 1 hr.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A R Cole

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Cora Matlock

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W W Matlock
(Address) Meridian Idaho

15. Filed April 3rd 1914
O L Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 3d 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2d 1914, to April 2d 1914, that I last saw him alive on April 2nd 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Gillbourne
Cause of death - Small premature baby
(Duration) Yrs. mos. ds.
Contributory (Secondary) 0
(Duration Yrs. mos. ds.
(Signed) Chas Bruce M. D.
April 3 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Idg
DATE OF BURIAL: April 3 1914
20. UNDERTAKER: Terry & Summers
ADDRESS: Boise Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Kuna.
(No. ..., ... St.)
Registration District No. ...
Primary Registration District No. ...
File No. 4359
Registered No. ...
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Edwin Edgar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1914 (Year)

7. AGE: ... yrs. ... mos. 11 ds.
IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Kuna

10. NAME OF FATHER: Dale Edgar.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lulu Stuart.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. H. Edgar
(Address) Kuna. Per C. L. Dutton

15. Filed Feb 23 1914. C. L. Dutton, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20th 1914, to Feb 22nd 1914, that I last saw him alive on Feb 20th 1914, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Inanition:-
...
...
(Duration) ... yrs. ... mos. 11 ds.
Contributory (Secondary) Weak & poor digestive powers with poor quality of milk.
(Duration) ... yrs. ... mos. 11 ds.
(Signed) C. L. Dutton M. D.
2/11 1914 (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: On Farm
DATE OF BURIAL: Feb 24 1914

20. UNDERTAKER: None
ADDRESS: C. L. Dutton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 7360
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian 6½ Mi. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Beckdolt.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec. (Month) 17½ (Day) 1886 (Year)

7. AGE: 27 yrs. 2 mos. 18 ds.
IF LESS than 1 day how many .....*hrs. or* .....*mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): General agriculture.

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: L. W. Beckdolt.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Leah Finch

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Beckdolt
(Address) Kuna, Idaho.

15. Filed March 7 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1914, to March 7 1914, that I last saw him alive on March 6 1914, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis (pulmonary) Contracted from mother's side - 1904 -
About
(Duration) 6 yrs. — mos. — ds.
Contributory Measles - 1905 -
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Dutton M. D.
3/7 - 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. ~~PLACE OF BURIAL~~ OR REMOVAL: To Indiana — DATE OF BURIAL 191

20. UNDERTAKER: S. B. Shullabarger. — ADDRESS Nampa.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)

File No. 7361
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Clyde Orgill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July 9 (Month) (Day) 1899 (Year)

7. AGE: 14 yrs. 7 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wiglin Orgill

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Catharine Bibb

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Silas D Woodle
(Address) St Anthony Idaho

15.
Filed Apr 9 1914 W B Swett, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1914, to Feb 12 1914 that I last saw h... alive on Jan 14 1914, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma.

(Duration) 0 yrs. 0 mos. 1 ds.

Contributory (Secondary) Diabetes

(Duration) ... yrs. 6 mos. 4 ds.

(Signed) Earl R Inabnett M. D.

Feb 14 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Parker
DATE OF BURIAL: Feb 16 1914

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of Parker
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

File No. 7362
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tadaru Kanito

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Brown	Single

6. DATE OF BIRTH
Mar 1 1914
(Month) (Day) (Year)

7. AGE
..... yrs. ..... mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Parker Idaho

10. NAME OF FATHER T Kanito

11. BIRTHPLACE OF FATHER
(State or Country) Japan

12. MAIDEN NAME OF MOTHER Takaio Yamamoto

13. BIRTHPLACE OF MOTHER
(State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Evans
(Address) St Anthony Idaho

15.
Filed Apr 9 1914 W D Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1914, to May 19 1914, that I last saw him alive on May 19 1914 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Spinal Bifida

(Duration) ..... yrs. ..... mos. 20 ds.

Contributory (Secondary) Meningitis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W D Evans M. D.

21 1914 (Address) St Anthony Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker Idaho
DATE OF BURIAL: 22 1914

20. UNDERTAKER: None
ADDRESS: None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99 2177

Primary Registration District No. 2177

(No. ....., ... St.)

File No. 7363

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah A Robbins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Jan 25 1847
(Month) (Day) (Year)

7. AGE

67 yrs. 2 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Peter Huffines

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Sarah Boothe

13. BIRTHPLACE OF MOTHER (State or Country) Philadelphia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) F. J. Robbins

15.

Filed Apr 9 1914 W Beard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 26 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at any time 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Senility. Tells me deceased has been paralyzed Motor Paralysis for 4 yrs and 4 mos confined to be fed for last time

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Wells M. D.

19.... (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? Not Physician in attendance

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Teton Ida	29 1914
20. UNDERTAKER	**ADDRESS**
W. A. Gray	St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 3177

(No. ..... St.)

File No. 7364

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Polly Chatmen Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Mar 21 1851
(Month) (Day) (Year)

7. AGE

62 yrs. 11 mos. 39 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER Levi Hammon

11. BIRTHPLACE OF FATHER (State or Country) ~~Polly C Davis~~ Mo

12. MAIDEN NAME OF MOTHER ~~Polly Chatmen Davis~~

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W B Davis

(Address) St Anthony Jak RD #7

15.

Filed Apr 9 1914 W B Swett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 24 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1914, to May 24 1914

that I last saw h[illegible] alive on May 24 1914,

and that death occurred on the date stated above, at 6.48 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory Mitral regurgitation

(Secondary)

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) W B Swett M. D.

3-6 1914 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Wilford Ida

DATE OF BURIAL: 27 May 1914

20. UNDERTAKER: None

ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2171
File No. 7365
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oliver Hyrum Spillman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1913 (Year)

7. AGE: 1 yrs. 4 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Milford Pocatello Ida

10. NAME OF FATHER: William Spillman

11. BIRTHPLACE OF FATHER (State or Country): London England

12. MAIDEN NAME OF MOTHER: Carrie Eggertz

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Moorfield
(Address) St Anthony Ida

15. Filed Apr 9 1914 W Brewer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 1914, to Mar 29 1914, that I last saw him alive on Mar 29 1914, and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) ..... yrs. ..... mos. 4 ds.
Contributory —
(Secondary)
(Duration) — yrs. ..... mos. ..... ds.

(Signed) J Moorfield M. D.
19..... (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford — DATE OF BURIAL: May 31 1914

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 7366
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Child

6. DATE OF BIRTH [redacted] (Month) 7 (Day) 1912 (Year)

7. AGE 1 yrs. 11 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER A. B. Morris

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Mch 10 1914 Ray A. Fuller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1914, to Jan 17 1914, that I last saw h[illegible] alive on Jan 17 1914 and that death occurred on the date stated above, at 12 3/4 M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... yrs. ..... mos. 16 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.

Jan 19 1914 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pocatello — DATE OF BURIAL Jan 19 1914

20. UNDERTAKER M. Peck & Sons — ADDRESS Rigby Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 9176
File No. 7367
Registered No. 2

1. PLACE OF DEATH.
County of Jefferson
City of Goodfield
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Violet Thomas.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W	Single

6. DATE OF BIRTH: Dec. 23 1913
(Month) (Day) (Year)

7. AGE: ..... yrs. 1 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Child.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Benj Thomas.

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Virgilia Reese

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Chas Jensen
(Address) Goodfield.

15. Filed Mch 10 1914 Ray A. Tucker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 18 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No physician in attendance. Probably
(Duration) ..... yrs. ..... mos. ..... ds.
Broncho Pneumonia
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray A. Tucker M. D.
Feb 19 1914 (Address) Ryby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Grant. DATE OF BURIAL: Feb. 20 1914

20. UNDERTAKER: A. Friends ADDRESS: Goodfield.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

County of Jefferson

Primary Registration District No. 2196

File No. 7368

City of Ryeburg

(No. ....., ... St.)

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Hill

If death occured in hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M	W	[illegible]

6. DATE OF BIRTH: May (Month) 2 (Day) 1849 (Year)

7. AGE: 64 yrs. 10 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER George Hill

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Hill.
(Address) Ryeburg Rd. 2

15.
Filed Apr 10 1914 Ray H Fiske.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 23 1914, to Mar 23 1914, that I last saw him alive on Mar. 23 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H Fiske. M. D.
Apr 10 1914 (Address) Ryeburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ryeburg, Ida.	Mar 25 1914

20. UNDERTAKER	ADDRESS
M. T. Peck & Sons.	Ryeburg.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Roberts
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 1305
Registered No. 8
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barbara A. Hibbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Baby

6. DATE OF BIRTH: March 11 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Eugene Hibbert

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Dolores Bonnet

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Eugene Hibbert
(Address): Roberts Ida

15. Filed Apr 10 1914 Ray Hicks Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch 20 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 11th 1914 to Mch 20 1914
that I last saw he alive on Mch 19 1914
and that death occurred on the date stated above, at 11a M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Jones M. D.
Apr 11 1914 (Address) Roberts Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roberts — DATE OF BURIAL: Mch 21 1914

20. UNDERTAKER: C. E. Dunwoody — ADDRESS: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 1182
Registered No. 7
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Bate

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W.	Married Widow

6. DATE OF BIRTH: July 19 1848 (Month) (Day) (Year)

7. AGE: 65 yrs. 8 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER Wm Shelly.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Dolcet Knight

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. A. Bate
(Address) Rigby R/F/D 1

15. Filed Apr 10 1914 Ray S. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: ~~March~~ Apr. 1 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1914 to Apr 1 1914
that I last saw her alive on Mch 27 1914
and that death occurred on the date stated above, at 7a. M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Carcinoma of Gall Bladder
(Duration) 1 yrs. ..... mos. ..... ds.
Contributory + Stomach.
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray S. Fuller M. D.
Apr 1 1914 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....dsys.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewisville-Ind Cem | DATE OF BURIAL: Apr 2, 1914

20. UNDERTAKER: Dunwoody | ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Jefferson

City of Rudy

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98

Primary Registration District No. 2176.

(No. ....., ... St.)

File No. 7371

Registered No. 46.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Lenora Radford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Dec 16 (Month) (Day) 1913 (Year)

7. AGE: ..... yrs. 2 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country): Rudy Ida.

10. NAME OF FATHER: James Radford

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jennie Carpenter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Radford
(Address) Rudy R.D. 2

15. Filed Apr 10 1914 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 11 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 7 1914, to Mch. 11 1914, that I last saw her alive on Mch. 11 1914, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.

19..... (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Shelton Cemetery — DATE OF BURIAL: Mch 13 1914

20. UNDERTAKER: Friends — ADDRESS: Rigby Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 7372
Registered No. 5

1. PLACE OF DEATH.
County of Jefferson
City of Mudfield
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Byron Clifford Warner
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: June (Month) 17 (Day) 1874 (Year)

7. AGE: 40 yrs. ..... mos. 1 ds. 19
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fillmore village Co Utah

10. NAME OF FATHER: Byron Warner

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Cristophira Tyler

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Myron Warner
(Address) Rigby R 1 Ida

15. Filed Mch 10 1914 Ray S. Fisher Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch 9 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 4 1914 to Mch 9 1914
that I last saw h[e] alive on Mch 8 1914
and that death occurred on the date stated above, at 2a. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) La Grippe
(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) Ray S. Fisher M. D.
Mch 10 1914 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [redacted] DATE OF BURIAL: Mch 11 1914

20. UNDERTAKER: Downerday Funeral Co ADDRESS: Idaho Falls Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 7373
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas H. Wunder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
Apr. 17 (Month) (Day) 1835 (Year)

7. AGE
79 yrs. 10 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER David Wunder

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas H. Wunder Jr.
(Address) Idaho Falls. R.D.5.

15.
Filed Mch 10 191 4 Ray B. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mch 6 (Month) (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Ry Fisher
Senility. Syncope
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Debility.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ray B. Fisher M. D.
Mch 19 14 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grant Cemetery. DATE OF BURIAL: Mch 8 191 4

20. UNDERTAKER: Friends and Family ADDRESS: Grant

Directed by Undertaking Co. Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Oakley

(No. ....., ... St.)

Registration District No. 120

Primary Registration District No. 2199

File No. # 7376

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. William McCoy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 6 (Day) 1872 (Year)

7. AGE: 41 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Forester

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Wm McCoy

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Sarah Bailey

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Stone

(Address) Bellevue Idaho

15.

Filed Apr. 7 1914

E. P. Oldham
Local Registrar

BYRNE - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 31 1914, to April 5th 1914, that I last saw h... alive on April 5th 1914, and that death occured on the date stated above, at 2.20 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) 0 Yrs. 0 mos. 3 ds.

Contributory (Secondary) Cardiac failure

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) H. O. Howe M. D.

19..... (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellview Ida — DATE OF BURIAL: April 8 1914

20. UNDERTAKER: L. B. Gallagher — ADDRESS: Burley Ida

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7376

Name Geo. William McCoy

Date of Death April 5, 1914

Cause of Death Cardiac Failure

Contributary Cause of death Lobar Pneumonia

(Sign here) W. O. Nelson M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7377

Registration District No. 170
Primary Registration District No. 8199
(No. ..... St.)
Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Oakley

2. FULL NAME Dorcas Jeanette Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 28 (Day) 1860 (Year)

7. AGE: 52 Yrs. 5 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: George White

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Jeanette Sever

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. O. Nelson
(Address) Oakley Idaho

15. Filed 2/28 1914
E. P. Clark
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1913, to Feb 19th 1914, that I last saw her alive on Feb 19th 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage
Pneumonia
(Duration) ..... yrs. ..... mos. four ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Nelson M. D.
19..... (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley
DATE OF BURIAL: 2/12 1914

20. UNDERTAKER: H C Haught
ADDRESS: Oakley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7377

Name Dorcas Jeanette Lee

Date of Death Feb. 10. 1914

Cause of Death Cerebral Hemorrhage

Contributary Cause of death Chronic Nephritis

(Sign here) P. O. Hudson M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 737

1. PLACE OF DEATH.
County of Bannock
City of Alexander.

Registration District No. 53
Primary Registration District No. 2160.
(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilma Wilson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Black.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH: December 8 — 1907 (Month) (Day) (Year)

7. AGE: 6 yrs. 2 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Edward Wilson.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Maggie Brooks.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mother (Edward Wilson)
(Address) .....

15.
Filed ..... 1914 John H. Hubbard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February — 9 — 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16 — 1914, to Feby 9 — 1914 that I last saw her alive on Feb 3 — 1914 and that death occurred on the date stated above, at 3.15 P.M.

The CAUSE OF DEATH* was as follows:
Typhoid fever

..... (Duration) ..... yrs. 4 mos. — ds.
Contributory (Secondary) Meningitis
..... (Duration) ..... yrs. 1 mos. 15 ds.

(Signed) John H. Hubbard M. D.
Feb. 25. 1914 (Address) Grace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grace Idaho.
DATE OF BURIAL: Feb. 11 1914

20. UNDERTAKER: John Allen Jr.
ADDRESS: Grace.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7379
Registered No. 5

1. PLACE OF DEATH.
County of Clearwater
City of Orofino (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168

2. FULL NAME Peter Angrell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: 1882 (Year) 1 (Day) ..... (Month)
7. AGE: 32 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Simms
(Address) Orofino, Idaho
15. Filed April 1 1914 J. M. Daisley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 9th. (Month) (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 12th. 1912, to Feb. 9th. 1914 that I last saw him alive on Feb. 8th 1914 and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration) 2 yrs. ..... mos. ..... ds.
(Signed) John Simms M. D.
Feb 10 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wardner
DATE OF BURIAL: 9 1914
20. UNDERTAKER: Clarence R Hill
ADDRESS: Orofino, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 738
Registered No. 6

1. PLACE OF DEATH.
County of Clearwater
City of Orofino (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edward Linder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) 1874 (Day) 1 (Year)

7. AGE: 40 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Setter at saw mill
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Linens
(Address) Orofino, Idaho

15. Filed Feb 11 1914 J. McDaily Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 9th, 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3rd. 1913, to Feb. 9th. 1914 that I last saw him alive on Feb. 8th 1914 and that death occurred on the date stated above, at 10:30 a. M.

The CAUSE OF DEATH* was as follows:

Chronic Meningitis
TBS

..... (Duration) 1 yrs. ..... mos. ..... ds.
Contributory Insanity
(Secondary)
..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) John Linens M. D.
Feb. 10 1914 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Asylum Cemetery — DATE OF BURIAL: Feb. 11, 1914

20. UNDERTAKER: Clarence R. Hill — ADDRESS: Orofino, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 7381
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George A. Potter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: 1843 (Month) 1 (Day) (Year)

7. AGE: 71 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Accountant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Stevens
(Address) Orofino, Idaho

15.

Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 10th. 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16th. 1914, to Feb. 10th. 1914
that I last saw him alive on Feb. 9th 1914
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Grastritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity
..... (Duration) ½ yrs. ..... mos. ..... ds.

(Signed) John Stevens M. D.
Feb 11 1914 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn.
DATE OF BURIAL: 9 ..... 191...

20. UNDERTAKER: Clarence R. Hill
ADDRESS: Orofino, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7381

Name George A. Potter

Date of Death Feb. 10. 1914.

Cause of Death Gastritis - Chronic X

Contributary Cause of death Insanity.

(Sign here) John M. Givens M.D.

X. Cause unknown.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7382
Registered No. 8

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gusta Fred Lovinquist

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: 1893 (Month) 1 (Day) (Year)
7. AGE: 41 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER: ✓
11. BIRTHPLACE OF FATHER (State or Country): ✓
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (State or Country): ✓
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Simms
(Address) Orofino, Idaho
15. Filed April 1, 1914 J. McDaid Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 11th 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 25, 1907 1911, to February 11, 1914 that I last saw h[illegible] alive on February 10, 1914 and that death occurred on the date stated above, at 4:00 P.M.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia
(Duration) 1 yrs. ..... mos. ..... ds
Contributory (Secondary) Insanity
(Duration) 7 yrs. ..... mos. ..... ds.
(Signed) John W. Simms M. D.
Feb. 12 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Asylum Cemetery
DATE OF BURIAL: Feb. 13 - 1914
20. UNDERTAKER: Clarence R. Hill
ADDRESS: Orofino, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7383

Registered No. 9

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 7168
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1854 (Month) 1 (Day) (Year)

7. AGE: 64 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Simms
(Address) Orofino, Idaho

15. Filed April 1 1914 J. Mooney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 12th. (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st. 1910, to Feb. 12, 1914
that I last saw h.. alive on Feb. 11, 1914
and that death occurred on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary): Insanity
..... (Duration) 15 yrs. ..... mos. ..... ds.

(Signed) John Simms M. D.
Feb 13 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery
DATE OF BURIAL: Feb. 14 1914

20. UNDERTAKER: Clarence R. Hill
ADDRESS: Orofino, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7384
Registered No. 10

1. PLACE OF DEATH.
County of Clearwater
City of Orofino (No. ....., ... St.)
Registration District No. 90
Primary Registration District No. 2768
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charles Lescoe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: 1872 (Year) ..... (Month) 1 (Day)
7. AGE: 42 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: ✓
11. BIRTHPLACE OF FATHER (State or Country): ✓
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (State or Country): ✓
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Stevens
(Address) Orofino, Idaho
15. Filed Feb 19, 1914 — J. M. Hovey, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 17th. 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 17th. 1913, to Feb. 17, 1914
that I last saw him alive on Feb. 17th 1914
and that death occurred on the date stated above, at 10:00 P. M.
The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) 1 yrs. ..... mos. ..... ds.
(Signed) John W. Stevens M. D.
Feb 18 1914 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Fel. Asylum Cemetery — DATE OF BURIAL: Feb. 19 1914
20. UNDERTAKER: Clarence R. Hill — ADDRESS: Orofino, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7385
Registered No. 11

1. PLACE OF DEATH.
County of Clearwater
City of Orofino (No. ....., ... St.)
Registration District No. 90
Primary Registration District No. 2168
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Amanda Norquist

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1867 (Month) 1 (Day) (Year)

7. AGE: 47 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Nelsinen
(Address) Orofino

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 20th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 17th 1913, to February 20 1914 that I last saw her alive on Feb. 19th 1914 and that death occurred on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Insanity.
..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) John Nelsinen M. D.
Feb. 20 1914 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Asylum Cemetery — DATE OF BURIAL: Feb. 21 1914

20. UNDERTAKER: Clarence R. Hill — ADDRESS: Orofino Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7385

Name Amanda Norquist

Date of Death Feb. 20th. 1914

Cause of Death Pneumonia - Lobar

Contributary Cause of death Insanity.

(Sign here) John Gibbons M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 7386
Registered No. 12

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert A. Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) 1855 (Day) 1 (Year)

7. AGE: 59 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Millwright
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Simms
(Address) Orofino, Idaho

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 23rd. 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1913, to Feb. 23rd. 1914, that I last saw him alive on Feb. 23rd. 1914, and that death occurred on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:

Gastritis

(Duration) ..... yrs. 6 mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) John Simms M. D.
Feb. 24 1914. (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Post Falls
DATE OF BURIAL: ? 191...

20. UNDERTAKER: Clarence R. Hill
ADDRESS: Orofino, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7386

Name Robert A. Bell

Date of Death Feb. 23. 1914

Cause of Death Gastritis, chronic - X.

Contributary Cause of death Insanity

(Sign here) John Gibbons M.D.

X. Cause unknown.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

File No. 7387

Registered No. 13

County of Clearwater

City of Orofino (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Pearce Francis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1880 (Month) 1 (Day) (Year)

7. AGE: 34 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Timens
(Address) Orofino, Idaho

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 27 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1913, to Feb. 27 1914, that I last saw h.im alive on Feb. 27 1914, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Tenderitis

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Insanity

(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) John C. Timens M. D.

Feb 28 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Asylum Cemetery — DATE OF BURIAL: March 1, 1914

20. UNDERTAKER: Clarence R. Hill — ADDRESS: Orofino, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7387

Name Wm. Pearce Franceis

Date of Death Feb. 27, 1914.

Cause of Death Gastro-Enteritis - Chronic x

Contributary Cause of death Insanity.

(Sign here) John C. Givens M.D.

x Cause unknown.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7388
Registered No. 14

1. PLACE OF DEATH
County of Clearwater
City of ~~Orofino~~

Registration District No. 21
Primary Registration District No. 2168
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Hazel Thuber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~(Write the word)~~ Single

6. DATE OF BIRTH: Mar. 9 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Samuel R. Thuber

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Ethel Smith

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. R. Thuber
(Address) Orofino Ida

15.
Filed May 1 1914 J. McGarity
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 191..., to ..... 191....
that I last saw her alive on Mar 13 1914
and that death occurred on the date stated above, at 6.45 P.M.
The CAUSE OF DEATH* was as follows:

Not known

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle W Horswell M. D.
Mar 20 1914 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sanders Cemetery
DATE OF BURIAL: Mar 20 1914

20. UNDERTAKER: None
ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90
County of Canyon Primary Registration District No. 168
City of Nampa (No. ....., ... St.)
File No. 7389
Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Nelson Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write the word.*) Single

6. DATE OF BIRTH June (Month) 9 (Day) 1875 (Year)

7. AGE 43 yrs. 9 mos. 14 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Jno Nelson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Martha

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Hendrickson
(Address) Wapps, Ida

15. Filed Mch 24 1914 J. H. Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 23 (Day) 191X (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Wapps, Ida — DATE OF BURIAL Mch 25 191X

20. UNDERTAKER — ADDRESS —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21

Primary Registration District No. 2022

File No. 4390

Registered No. 9

1. PLACE OF DEATH.

County of Blaine

City of Hailey

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles W Jennings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 3 (Day) 1864 (Year)

7. AGE: 49 yrs. 10 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veterinary Surgeon
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C W Jennings
(Address)

15. Filed 3/15 1914 Porter L. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11, 1914, to Mar 13 1914 that I last saw h[e] alive on Mar 13 1914 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Cancer of the Liver

(Duration) yrs. 7 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward L. Wright M. D.

3/15 1914 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? Gooding

Former or usual residence Hailey

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hailey	3/15 1914

20. UNDERTAKER	ADDRESS
R. D. Harris	Hailey

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 7391
Registered No. 8

1. PLACE OF DEATH.
County of Blaine
City of Hailey
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John A. Compton.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 13. (Day) 1836 (Year)

7. AGE: 78 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. E. Fleming
(Address) Hailey

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March. (Month) 18. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1913, to Dec 17th 1913, that I last saw him alive on Dec 17th 1913, and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. 5 mos. ..... ds.

Contributory (Secondary): Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Kleinman M. D.

Mch 18 1914 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida. | DATE OF BURIAL: Mar 20th 1914

20. UNDERTAKER: W. D. Harris | ADDRESS: Hailey Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1111
(No. ....., ... St.)

File No. 7392
Registered No. 7
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Wohlleen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gardner Ida

10. NAME OF FATHER: Henry Wohlleen

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lena Pedan

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Wohlleen
(Address) Kellogg Idaho

15. Filed Feb. 3, 1914 H. S. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1914, to Feb 3 1914, that I last saw h[er] alive on Feb 3 1914 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Strangulated Congenital umbelical hernia

(Duration) ..... yrs. ..... mos. 21 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. Mowery M. D.
Feb 3 19 14 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Feb 4 1914

20. UNDERTAKER: Ward Undertaking Co
ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 7393
Registered No. 10

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME M. James Shannon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 68 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Patrick Shannon

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Catherine Pendergast

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lizzie E. Ward
(Address) Wallace Ida

15. Filed March 6 1914 — F. Leo Finch, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1914, to Mar 5 1914, that I last saw him alive on Mar 4 1914, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Mowry M. D.
3/6 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Mar 7 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1911
(No. Jameson Building St.)

File No. 7304
Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Agnes Ryan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. May (Month) 17 (Day) 1878 (Year)
7. AGE: 36 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Vermont
10. NAME OF FATHER Patrick Griffin
11. BIRTHPLACE OF FATHER (State or Country) Connecticut
12. MAIDEN NAME OF MOTHER Mary Welch
13. BIRTHPLACE OF MOTHER (State or Country) Mass
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John T. Ryan
(Address) Butte Mont.
15. Filed March 12 1914
Fr Leo Timmes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. March (Month) 11 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute Alcoholism
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D D Mowery M. D.
Mar 12 1914 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Butte Mont — DATE OF BURIAL: Mar 13 1914
20. UNDERTAKER: Bruce G Norstee — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 7395
Registered No. 12

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Greene

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 32 Yrs. — Mos. — ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: E. N. Greene

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary T. Pope

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Judd Greene
(Address) Oysterville, Wash.

15. Filed March 12 1914 H. Leo Quinby Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1914, to March 11 1914, that I last saw h-m alive on March 11 1914 and that death occured on the date stated above, at 11A. M.
The CAUSE OF DEATH* was as follows: Infarct Lung Liver
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Dr Mowry M. D.
Mar 12 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ackra — DATE OF BURIAL: March 13 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 6041
(No. ..... St.)

File No. 7396
Registered No. 13

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Barry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: 30 Yrs. — Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: John Barry.
11. BIRTHPLACE OF FATHER (State or Country): Ireland.
12. MAIDEN NAME OF MOTHER: Norah Staggerly
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Barry
(Address) St Joe Ida
15. Filed March 13 1914 F. Leo Smiley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 9 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 9 1914, to Mar 9 1914, that I last saw him alive on Mar 9 1914, and that death occured on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows: Pulmonary Tremens
(Duration) ..... Yrs. ..... mos. 2 30 ds.
Contributory (Secondary) Excessive Alcoholism
(Duration) ..... yrs. 6 mos. ..... ds.
(Signed) Dr. Thorburn M. D.
3/13 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	Mar 14 1914
20. UNDERTAKER	ADDRESS
Ward Undertaking	C. Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7397

Registered No. 12

Registration District No. 70

Primary Registration District No. 10 11

(No. Front Street St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

2. FULL NAME Edwin Nygren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 6th (Day) 1872 (Year)

7. AGE: 41 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): Finland

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Carl Nygren

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Lena Sampson

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Nymagn

(Address) Wallace Idaho

15. Filed March 14 1914 F. Lee Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1914, to March 10 1914, that I last saw him alive on March 10 1914 and that death occured on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:

Perforation of bowel

(Duration) ..... Yrs. ..... mos. 1/2 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

Signed D. P. Mowry M. D.

March 14 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Mar 15 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7398

Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10

Primary Registration District No. 1011

(No. ..... St.)

2. FULL NAME Carl Puska

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Akanhajaki Finland

10. NAME OF FATHER John Puska

11. BIRTHPLACE OF FATHER (State or Country) Akanhajaki D. L. Finland

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wards Undertaking Co

(Address) Wallace Idaho

15. Filed March 17 1914 H. Les Tinsley Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. March (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 9 M.

The CAUSE OF DEATH was as follows: Accidental due to gun shot penetrating abdomen near heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Chas. G. Mowatt M. D.

Mar 17 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Mar 18 1914

20. UNDERTAKER: Wards Undertaking Co — ADDRESS

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7399

Registered No. 16

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No 70

Primary Registration District No 10 11

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Dunbar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Musician

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wards Undertaking Co

(Address) Wallace Idaho

15. Filed Mar 17 1914 H. Lee Dunbar Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1914 to March 16 1914 that I last saw h alive on March 16 1914 and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Morphine Overdose

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... Mos. ..... ds.

(Signed) Chas. R. Mowery M. D.

Mar 17 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Mar 18 1914

20. UNDERTAKER: Wards Undertaking Co. — ADDRESS:

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone — Registration District No. 20

City of Idaho — Primary Registration District No. 1011

(No. ..... St.)

File No. 7400

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas OToole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1872 (Year)

7. AGE: 42 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lineman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Green Isle, Minn.

10. NAME OF FATHER: Dominick OToole

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Catharine Cain

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dominic OToole

(Address) Wallace Idaho

15. Filed March 18 1914 F. Leo Tingley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1914, to March 1914 that I last saw him alive on March 16 1914 and that death occured on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Woods M. D.

March 19 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash — DATE OF BURIAL: 3/19 1914

20. UNDERTAKER: Wards Undertaking Co. — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 3-15 R. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF [illegible]
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 16

Primary Registration District No. 10 11

(No. Providence Hospital St.)

File No. 7401

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Esther B. Wilmot

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. 3 (Month) 29 (Day) 1882 (Year)

7. AGE: 32 Yrs. 11 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Seleen

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Wilmot

(Address) Wallace, Idaho.

15. Filed Mar 19 1914 F. Leo Irwin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 16th 1914, to Mar 18th 1914, that I last saw her alive on Mar 18th 1914, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Puerpial eclampsia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. & C. R. Mowery M. D.

19..... (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Providence Hosp yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Wallace, Idaho.

Former or usual residence Wallace, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Spokane, Washington

DATE OF BURIAL: March 20 1914

20. UNDERTAKER: Bruce Worstell

ADDRESS: Wallace, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7402

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace (No. Fields Billiard Hall St.)

Registration District No. 70

Primary Registration District No. 6011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. P. Donovan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 38 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph F. Donovan
(Address) Wallace Idaho
March 20 1914

15. Filed March 20 1914 F. Lee Dunphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on 1914,
and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... Yrs. ... mos. ... ds.

(Signed) Dr. Mowry M. D.
May 20 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cherokee Lodge — DATE OF BURIAL: March 21 1914

20. UNDERTAKER: Bruce G. Woodell — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & ROBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 1011
File No. 7403
Registered No. 20

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Hoper Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Lyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 48 Yrs. ___ Mos. ___ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed March 28 1914 A. Leo Dingley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/22/14 1914, to 3/24/14 1914, that I last saw h. alive on 3/24/14 1914, and that death occured on the date stated above, at 7:30 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Pneumonia
(Duration) yrs. 6 mos. 14 ds.
(Signed) Howard E. Brown M. D.
1914 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 30 days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Pneumonia, Mont.
Former or usual residence Burke, Idaho

19. PLACE OF BURIAL OR REMOVAL Helena Mont. DATE OF BURIAL 3/28 1914

20. UNDERTAKER Ward Undertaking Co ADDRESS Wallace Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 43
County of Owyhee Primary Registration District No. 2120
City of Parrahuma Basin (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 7405
Registered No. 7
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Christian Bohren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Not known (Month) 1 (Day) (Year)

7. AGE: 50 yrs. 50 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher or ranch hand
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Mr Bohren

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Maria Bohren

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Altmanshofer
(Address) Parrahuma Basin

15. Filed March 31 1914 H. H. Schuyler, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20th 1914, to March 21st 1914
that I last saw him alive on March 21st 1914,
and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Tick Fever

(Duration) ..... yrs. ..... mos. 9 ds.
Contributory (Secondary) Congestion of lungs
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. W. Davis M. D.
March 22 1914 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenn's Ferry
DATE OF BURIAL: March 23d 1914

20. UNDERTAKER: C. Altmanshofer
ADDRESS: Parrahuma Basin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

...YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 43½

County of Owyhee Primary Registration District No. 2120

City of Silver Creek (No. ....., ... St.)

File No. 7406

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Quigney Francis Lambert

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: April (Month) 22d (Day) 1835 (Year)

7. AGE: 78 yrs. 10 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Nealeton
(Address) Murphy Ida.

15.
Filed March 18, 1914 W. H. Selumpler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 14th (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found dead in bed in his cabin, death being apparently due to natural causes, old age, (a) a bad cold on his lungs?)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Selumpler M. D.

March 17, 1914 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Silver City Cemetery next to K of P. DATE OF BURIAL: March 17th 1914

20. UNDERTAKER: Jo Lee Goetz ADDRESS: Silver City Ida

CAUSE OF DEATH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. ment of OCCUPATION is very important.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Kooskia

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106

Primary Registration District No. 2184

(No. ....., ... St.)

File No. 7401

Registered No. 1

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orlando Northrup

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: March (Month) 9 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ... 8 ... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Co.

10. NAME OF FATHER Charles Northrup

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Nancy Wiggins

13. BIRTHPLACE OF MOTHER (State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Northrup
(Address) Kooskia - Idaho

15. Filed March 10 1914 J.M. Verbeckmoes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1914, to ..... 191..., that I last saw h.. alive on March 10 1914 and that death occurred on the date stated above, at 7.40 A.M.

The CAUSE OF DEATH* was as follows:
Meningeal Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.M. Verbeckmoes M. D.
March 10 1914 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: March 10 1914

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2709
File No. 7408
Registered No. 19

1. PLACE OF DEATH.
County of Franklin
City of Weston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leola Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH: June (Month) 21 (Day) 1907 (Year)

7. AGE: 6 yrs. 7 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Western

10. NAME OF FATHER Nils E Hansen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Stoddard

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hyrum O Hansen
(Address) Weston Idaho

15. Filed March 25 1914 D Allen Rees Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1914, to Feb 16 1914, that I last saw her alive on Feb 16 1914, and that death occurred on the date stated above, at 1239 M.

The CAUSE OF DEATH* was as follows:
Cerebral abscess

(Duration) ..... yrs. ..... mos. one ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. W. Lueck M. D.
2/16 1914 (Address) Weston, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston — DATE OF BURIAL: Feb 17 1914

20. UNDERTAKER: D Hansen — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

Primary Registration District No. 2119

File No. 740

Registered No. 17

County of .....

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosina Talbot

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH: Feb (Month) 16 (Day) 1912 (Year)

7. AGE: 2 yrs. 1 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lewiston

10. NAME OF FATHER Albert E Talbot

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Clark

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert E Talbot

(Address) Preston

Filed March 25 1914 Dr. Allen R Dustin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1914, to Mar 19 1914, that I last saw her alive on Mar 18 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M M Parkinson Jr M. D.

19 ..... (Address) Lewiston Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairview	Mar 22 1914

20. UNDERTAKER	ADDRESS
Not Any	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 7411
Registered No. 21

1. PLACE OF DEATH.
County of Madison
City of Rexburg (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Gilroy Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 2 (Day) 913 (Year)

7. AGE: ..... yrs. 3 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Andrew J. Hansen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Maud Lee

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Hansen
(Address) Rex

15. Filed 3-19 1914 G. G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-18 1914, to 3-18 1914, that I last saw h-- alive on 3-18 1914, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. G. Espe M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spencer Idaho	Mar 20 1914

20. UNDERTAKER	ADDRESS
J. M. Williams	Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178
City of Burton (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 7412
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME M Sakaguchi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: March (Month) 31 (Day) 1895 (Year)

7. AGE: 18 yrs. 11 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: K. Kayama

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Zuruki Yoshihara

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. Sasaki
(Address) Rex. #1

15. Filed 3-19 1914 G. W. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-7 1914, to 3-19 1914, that I last saw her alive on 3-18 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Brights disease
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. W. Espe M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 3/19 1914

20. UNDERTAKER: John Schaeffer — ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 7413
Registered No. 23

1. PLACE OF DEATH.
County of Madison
City of Sunnydell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donnel Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1913 (Year)

7. AGE: 1 yrs. 1 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry Taylor

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Hazel Madson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eliza Buckland
(Address) Sunnydell

15. Filed 3-21 1914 L. L. Eske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/13 1914, to 3/21 1914, that I last saw h... alive on 3/21 1914 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Wallace M. D.
19 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sunnydell	3/22 1914

20. UNDERTAKER	ADDRESS
John Phillips	Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 714

Registered No. 24

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Madison

City of Rexburg

2. FULL NAME Yoshi Hanama

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 15 (Day) 1914 (Year)

7. AGE ....Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER S. Hanami

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER C. Inomata

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 3-27 1914 G.G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 3 P.M. 1914, to Mar 25 4 P.M. 1914, that I last saw h[e] alive on Mar 25 at 4 P.M. 1914, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

Tuberculosis

.....(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Weeks M. D.

Mch 1914 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg

DATE OF BURIAL 3/27 1914

20. UNDERTAKER John Phillips

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 745
Registered No. 25

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene Ricks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Apr (Month) 15 (Day) 1912 (Year)

7. AGE: 1 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. C. Ricks jr

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Maud DuBell

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Phillips
(Address) Rex

15. Filed 4-2 1914 G. G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-24 1914, to 4-2 1914, that I last saw h.im alive on 4-2 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 4-3 1914

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SOBS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 741
Registered No. 14

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W	

6. DATE OF BIRTH: Sept 11 (Month) + (Day) 1854 (Year)

7. AGE: 59 yrs. 6 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: dont know

11. BIRTHPLACE OF FATHER (State or Country): dont know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S. L. Spangler
(Address) Caldwell, Ida.

15.
Filed Mar. 17 1914 — Jake S. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to March 13 1914, that I last saw h.r alive on March 13 1914, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus & Sigmoid
(Duration) not known yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. W. Lee M. D.
3/14 1914 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 3/18 1914

20. UNDERTAKER: W. C. Dyer
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 743
Registered No. 15

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. 1010, Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Roberts

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	German	Widower

6. DATE OF BIRTH
June (Month) 1st (Day) 1832 (Year)

7. AGE
82 yrs. 3 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoe Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Worms

10. NAME OF FATHER Frank Roberts

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. A. Roberts
(Address) Caldwell Idaho

15.
Filed Mar. 15 - 1914 John S. Mayes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/9/14 191..., to 3/13/14 191..., that I last saw her alive on 3/13/14 191..., and that death occurred on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:
Bilateral Lobar Pneumonia

(Duration) ... yrs. ... mos. 4 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm. H. Thurston M. D.
3/14/14 19... (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 3/15 1914

20. UNDERTAKER: W. E. Dyer
ADDRESS: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 7410
Registered No. 16

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ferdinand Hoffman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH: Mch (Month) 17 (Day) 1842 (Year)

7. AGE: 71 yrs. 11 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baker.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): ✓ ✓

12. MAIDEN NAME OF MOTHER: ✓ ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. Faris
(Address) Caldwell Ida

15.
Filed Mar. 17th 1914 John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1913, to March 13 1914
that I last saw h— alive on March 10 1914
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy, Instantaneous
Nov 20th 2nd stroke
March 10th 1913

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Miller M. D.
3/15 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill | DATE OF BURIAL: 3/18 1914

20. UNDERTAKER: W. E. Dyer | ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 2 1 5 2

File No. 7420
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Wm H Hyde

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
62 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Ontario Canada

10. NAME OF FATHER: Jas Dunn

11. BIRTHPLACE OF FATHER
(State or Country) Carlisle England

12. MAIDEN NAME OF MOTHER: Mary Spinsby

13. BIRTHPLACE OF MOTHER
(State or Country) Douglas Isle of Man

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Dunn
(Address) St Louis.

15.
Filed Mar 24 1914 E C [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 18th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1914, to Mch 18 1914, that I last saw her alive on Mch 17 1914, and that death occurred on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:
Mastoiditis followed by Meningitis

(Duration) ✓ yrs. ✓ mos. — ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G H Coulthard M. D.
3/24 1914 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 3/22 1914

20. UNDERTAKER: Downey Funeral
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7421

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Bonneville

City of Idaho Falls (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melvin LeRay Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH: Aug (Month) 24 (Day) 1913 (Year)

7. AGE: X yrs. 6 mos. 19 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho Falls, Ida

10. NAME OF FATHER C. S. Nelson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Emma Jernon

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. S. Nelson

(Address) Ida Falls, Ida

15. Filed Mch 17 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 9 - 1914, to Mch. 15 1914, that I last saw h[illegible] alive on Mch. 15 - 1914, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ✓ yrs. ✓ mos. ✓ ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) G. H. Coulthard M. D.

3-17 1914 (Address) Idaho Falls. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Idaho Falls, Ida — DATE OF BURIAL: 3/18 1914

20. UNDERTAKER: C. E. Linwood — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7422

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2150

(No. ____, ____ St.)

2. FULL NAME Mrs Tsuya Tanaka

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Japanese	married

6. DATE OF BIRTH: Dec. (Month) 26 (Day) 1894 (Year)

7. AGE: 19 yrs. ____ mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Tomekichi Takahashi

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: ____

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. Tanaka
(Address) Idaho Falls

15. Filed Mar 14 1917 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 13 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Run over by train
Probably accidental

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ____

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jos. Manley Coroner

3/14 19... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Idaho — DATE OF BURIAL: 3/14 1917

20. UNDERTAKER: Linworthy F. C. — ADDRESS: I. Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7424

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Ammon Prec. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. 21

2. FULL NAME John Alvin Glausman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 20 (Day) 1892 (Year)

7. AGE: 31 yrs. 10 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Benedict Glausman

11. BIRTHPLACE OF FATHER (State or Country): Switz.

12. MAIDEN NAME OF MOTHER: Emma Kramer

13. BIRTHPLACE OF MOTHER (State or Country): ~~Ia~~ Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Glausman
(Address) R.D. 3 - City.

15. Filed March 11 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1913, to March 9 1914, that I last saw him alive on March 8 1914, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) ? yrs. ? mos. ? ds.

Contributory ?
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

3/12 1914 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Idaho Falls	3/1 1914

20. UNDERTAKER	ADDRESS
C. E. Dimmoodey	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 19760

7426

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

File No. 7426

County of Idaho

City of Sisters (No. ....., ... St.)

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lovica Savon Skaggs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July 29 1912 (Month) (Day) (Year)

7. AGE: 1 yrs. 8 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Skaggs

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Alice Wenner

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) mrs R. A. Lyle
(Address) Sisters Idaho

15.
Filed April 30 1914 Jno. Verbeek Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1914, to April 28 1914, that I last saw h[illegible] alive on April 28 1914 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Acute Peritonitis probably
[illegible]
(Duration) ..... yrs. ..... mos. 3 ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. Verbeek M. D.
April 28 1914 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cemetery — DATE OF BURIAL: April 30 1914

20. UNDERTAKER: mrs R. A. Lyle Sisters Idaho — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7426

Name Leora Savon Skaggs

Date of Death Apr. 28, 1914.

Cause of Death Acute peritonitis - probably resulting

Contributary Cause of death from Appendicitis

(Sign here) J. M. Verbenkamp M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Kootenai (No. ....., ... St.)

Registration District No. 106

Primary Registration District No. 2184

File No. 7427

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Scott Newland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

May (Month) 25 (Day) 1839 (Year)

7. AGE

74 yrs. 11 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Newland.

(Address) Kootenai, Idaho

15.

Filed April 30 1914 J. M. Verbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1914, to April 29 1914, that I last saw h in alive on April 29 1914 and that death occurred on the date stated above, at 8.00 P.M.

The CAUSE OF DEATH* was as follows:

Hemalemesis (probably from Gastric ulcer

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Verbeck M. D.

April 30 1914 (Address) Kootenai.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Newland Cemetery (Private)	May 1 1914

20. UNDERTAKER	ADDRESS
None	

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 122

Primary Registration District No. 2202

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 742

Registered No. 7

1. PLACE OF DEATH.

County of Shoshone

City of Burke, Ida

(No. Burke Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John George Gruennald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. 2 (Month) 26 (Day) 1914 (Year)

7. AGE: 0 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burke Idaho

10. NAME OF FATHER: Geo N Gruennald

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Henrietta Mayer

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo L Grunewald

(Address) Burke Idaho

15. Filed Apr 23 1914 H. C. Mowry Local Registrar

BYNS - YORK CO., PRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 17 1914, to Apr 20 1914, that I last saw him alive on Apr 20 1914 and that death occured on the date stated above, at 7:00 P. M.

The CAUSE OF DEATH* was as follows:

Acute Hydrocephalus

(Duration) Yrs. mos. 6-7 ds.

Contributory (Secondary) Meningitis

Duration Yrs. mos. 8 ds.

(Signed) Chas A Pittman M. D.

4/22 1914 (Address) Burke, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: 4/22 1914

20. UNDERTAKER: Bruce & Worstell — ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. [illegible]
Primary Registration District No. 1064
File No. 719
Registered No. 7

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ethel Williams Camp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1889 (Year)

7. AGE: 24 Yrs. 5 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malad City Idaho

10. NAME OF FATHER: William D. Williams

11. BIRTHPLACE OF FATHER (State or Country): Wales Wales

12. MAIDEN NAME OF MOTHER: Hannah Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Wales Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alvin M. Camp
(Address) Malad R F D No 1

15.
Filed 3/16 1914
D C Ray
Local Registrar

SYMS - YORK CO., PTRS. & BGRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1914, to Mar 14 1914, that I last saw h[illegible] alive on Mar 12 1914, and that death occured on the date stated above, at 3.40 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

3/16 1914 (Signed) J. F. Alton M. D.
(Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Mar 17 1914

20. UNDERTAKER: D. S. Johnson — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1430

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
Registration District No. 12
Primary Registration District No. 2118
(No. ....., ... St.)
Registered No. 410

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Fox

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: German
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Sept (Month) 9 (Day) 1829 (Year)
7. AGE: 84 yrs. 7 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Washington
10. NAME OF FATHER: Jacob Fox
11. BIRTHPLACE OF FATHER (State or Country): Russia
12. MAIDEN NAME OF MOTHER: Mary Kindofather
13. BIRTHPLACE OF MOTHER (State or Country): Russia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob Fox
(Address) Glenn's Ferry, Ida
15. Dr. D. Dorgueene 5/10/14
Filed April 22 1914 Wm. J. Engler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 21 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 19 1914, to April 21 1914 that I last saw him alive on April 21 1914 and that death occurred on the date stated above, at X M.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
..... (Duration) — yrs. 1 mos. — ds.
Contributory (Secondary) Senile Gangrene
..... (Duration) — yrs. — mos. 3 ds.
(Signed) J. R. Ballard M. D.
April 21 1914 (Address) Burns, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Walla Walla, Wash. DATE OF BURIAL: Apr 25 1914
20. UNDERTAKER: Shumway ADDRESS: Jackson, Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Desmet

Registration District No. 12
Primary Registration District No. 2018
(No. ....., ... St.)

File No. 7131
Registered No. 406

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Basil Deistas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH
— (Month) — (Day) 1856 (Year)

7. AGE
48 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kalispel

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Marshal
(Address) Kamiah, Ida.

15. D D Freeman 3/10/14
Filed March 23 1914 Wm D Langton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Epidemical Pneumonia
Acute Gastritis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Desmet
DATE OF BURIAL: March 22 1914

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Spt Lake

Registration District No. 12
Primary Registration District No. 2087
(No. ....., ... St.)

File No. 743
Registered No. 409

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Ida Smith.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Apr (Month) 28 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 1½ ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spirit Lake

10. NAME OF FATHER: Barney Smith

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Sophie Klawiter

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 5/20 191 D. D. Spencer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr 29 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1914, to Apr 29 1914 that I last saw h[illegible] alive on Apr 26 1914 and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Convulsions -

..... (Duration) ..... yrs. ..... mos. 36 hrs. ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dash D Smith M. D.
Apr 29 1914 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spt Lake
DATE OF BURIAL: 6/29 1914

20. UNDERTAKER: Shaw
ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1135
Registered No. 408

1. PLACE OF DEATH. , Registration District No. 12
County of Kootenai Primary Registration District No. 2051
City of Spirit Lake (No. ..., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary L O'Donnell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Mar (Month) 3 (Day) 1889 (Year)

7. AGE: 25 yrs. 1 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky

10. NAME OF FATHER: M. M. Bowers

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Ellen Little

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. M. Bowers
(Address) Spirit Lake Ida.

15. Filed 5/10 1914 D. L. Drumm Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1914, to Apr 28 1914
that I last saw h[illegible] alive on Apr 28 1914
and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Nephritis Acute

(Duration) 25 yrs. 6 mos. 23 ds.

Contributory (Secondary) ..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Earl L Prindle M. D.
Apr 28 1914 (Address) Spirit Lake Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Spirit Lake ..... yrs. ..... mos. 14 ds. In the Prindle Hospital State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? U.S. Navy
Former or usual residence Spirit Lake Ida

19. PLACE OF BURIAL OR REMOVAL: Bartlett — DATE OF BURIAL: 4/30 1914

20. UNDERTAKER: Kloss — ADDRESS: Bartlett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Hauser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2015
(No. ....., ... St.)

File No. 7431
Registered No. 405
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mike Fenlon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH
..... (Month) ..... (Day) 1843 (Year)

7. AGE
71 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Fenlon

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Cogan
(Address) Hauser

15.
Filed 5/10 1914 D D Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914; to Date 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Old age

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Degestive Complex
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Brennan M. D.
4/16 1914 (Address) Post Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Trent Cemetery	4/16 1914
20. UNDERTAKER	ADDRESS
Done	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 743

Registration District No. 11
Primary Registration District No. 2003

1. PLACE OF DEATH.
County of Ada
City of Kuna
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Clarence Martin

Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH
Feb. (Month) 23 (Day) 1884 (Year)

7. AGE
30 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work ..... Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER J. C. Martin

11. BIRTHPLACE OF FATHER (State or Country) W. Va.

12. MAIDEN NAME OF MOTHER Mary L. Walker

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Martin
(Address) Kuna Ada

15.
Filed April 14 - 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1914, to April 13 1914
that I last saw him alive on April 6 1914
and that death occurred on the date stated above, at 8-45a M

The CAUSE OF DEATH* was as follows:
Consumption

(Duration) One yrs. ..... mos. ..... ds

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds

(Signed) J. A. Martin M. D.
April 13 1914 (Address) Homedale Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... d
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kuna Cemetery	4/14 1914

20. UNDERTAKER	ADDRESS
F. K. Coleman #19	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7436
Registered No.

1. PLACE OF DEATH. Registration District No. 11
County of Ada
City of Meridian (No. ....., ... St.)
Primary Registration District No. 2003.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Nettie Hall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed.
6. DATE OF BIRTH: Oct. (Month) 10 (Day) 1841 (Year)
7. AGE: 72 yrs. 7 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer): ——
9. BIRTHPLACE (State or Country): Scott Co. Ind.
10. NAME OF FATHER: Ritchie
11. BIRTHPLACE OF FATHER (State or Country): Some place in U. S.
12. MAIDEN NAME OF MOTHER: Not obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) J. C. Ulmer - Meridian (a son) - C. L. Dutton
15.
Filed May-12 1914 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May. (Month) 11th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 20th 1914, to May-11th 1914 that I last saw her alive on May-11th 1914 and that death occurred on the date stated above, at 2.30 P.M.
The CAUSE OF DEATH* was as follows:
Feeble heart - Arteriosclerosis
Interstitial nephritis,
..... (Duration) number of years — yrs. mos. ds.
Contributory (Secondary) Uraemia Poison — nephritis.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Dutton M. D.
May-12 1914 (Address) Meridian —

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: May 12th 1914
20. UNDERTAKER: Christen & Sidener — ADDRESS: Boise

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 713
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Meridian (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Darsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 18th (Day) 1875 (Year)

7. AGE: 38 Yrs. 9 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho City, Idaho

10. NAME OF FATHER: John Ritchie

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Cecelia Burwash

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. Davis Emma
(Address) Meridian

15. Filed May 9th 1914 — C. R. Dutton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to May 8 1914, that I last saw her alive on May 7 1914, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows: Pneumonia Bronchial

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Herbert F. Neal M. D.

May 9 1914 (Address) Meridian Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: 5/9 1914

20. UNDERTAKER: Schreiber & Sidenfad — ADDRESS: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24654

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7437

Name Emma Darsey

Date of Death May 8, 1914.

Cause of Death Bronchial Pneumonia

Contributary Cause of death Senile Coed

(Sign here) H. F. Neaf M.D.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 713

Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2003

2. FULL NAME Tina Bell Kyle

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1888 (Year)

7. AGE: 25 yrs. 7 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boone Co Ark

10. NAME OF FATHER: Washington L. Kindle

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Mary L. Bittle

13. BIRTHPLACE OF MOTHER (State or Country): Boone Co Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Tindall
(Address) Meridian Idaho

15. Filed Apr 23 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1914, to April 22 1914 that I last saw her alive on April 22 1914 and that death occurred on the date stated above, at [redacted] P. M.

The CAUSE OF DEATH* was as follows:
Toxaemia from intestines
(Duration) yrs. mos. 10 ds.
Contributory (Secondary) Salivation
(Duration) yrs. mos. ds.

(Signed) Halbert F. Neal M. D.
April 23 1914 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence:

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery
DATE OF BURIAL: April 24 1914
20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7437
Registered No.

1. PLACE OF DEATH.
County of Boise
City of Arrowrock
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2131
(No. ....., ... St.)

2. FULL NAME H. Sandvik

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) ?

6. DATE OF BIRTH: ? (Month) 1 (Day) ? (Year)

7. AGE: ? yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): Construction of Dam

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James P. Kerby, M.D.
(Address) Arrowrock, Idaho

15.
Filed 5/13 1914 James P. Kerby M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1914, to May 13 1914 that I last saw him alive on May 13 1914, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Fractures of skull & internal injuries. Head struck rock was accidentally killed on this man
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Accidental
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James P. Kerby M. D.
May 13 1914 (Address) Arrowrock, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 ds. In the State ? yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence ?

19. PLACE OF BURIAL OR REMOVAL: Boise
DATE OF BURIAL: May 16 1914

20. UNDERTAKER: Shreiber & Liddenfelden
ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 18872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of Arrowrock
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2131
(No. ....., ... St.)

File No. 714
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Chas Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	?

6. DATE OF BIRTH
? (Month) 1 (Day) ? (Year)

7. AGE
? yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs.or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... laborer
(b) General nature of industry business or establishment in which employed (or employer) ..... Construction of Dam

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James P Kerby, M.D.
(Address) Arrowrock Ida

15.
Filed 5/13 1914 James P Kerby, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 13 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1914, to May 13 1914 that I last saw him alive on May 13 1914, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Fracture of skull & body injuries (Death instantaneous) due to accidental spilling of load of rock
(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) accidental
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James P Kerby M. D.
May 13 1914 (Address) Arrowrock, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ? mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL
Boise
DATE OF BURIAL
May 17 191

20. UNDERTAKER
Shreiber & Siddenfadden
ADDRESS
Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of Arrowrock
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2131
(No. ....., ... St.)

File No. 741
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Needham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write the word.*): single

6. DATE OF BIRTH: Unknown (Month) ..... (Day) 1873 (Year)

7. AGE: 41 yrs. ? mos. ? ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ?

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Based on statements of deceased
(Address) James P Kerby M.D. Arrowrock, Ida.

15.
Filed 3/18 1914
James P Kerby
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1914, to March 18 1914
that I last saw h[im] alive on March 1914,
and that death occurred on the date stated above, at 4-20a. M.

The CAUSE OF DEATH* was as follows:
Shock following operation & Crushing of both legs and head by wood falling on him.
(Duration) ..... yrs. ..... mos. ½ ds.
Contributory (Secondary) Double compound comminuted multiple fractures tibia & fibula
(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) James P Kerby M. D.
3/18 1914 (Address) Arrowrock, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ? mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence ?

19. PLACE OF BURIAL OR REMOVAL: Boise, Ida. DATE OF BURIAL: 3/20 1914

20. UNDERTAKER: Schrock & Eddington ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

File No. 7442

County of .....

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel Irene Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15.

Filed ..... 191.....

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 15th 191 4
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191.....,
that I last saw h..... alive on ..... 191.....,
and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Typhoid Fever

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) H.N. Gragg .....M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL .....191.....

20. UNDERTAKER | ADDRESS

DO NOT HARD COPY PRINT

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7442

Name Rachel Irene Taylor

Date of Death Jan 15, 1914.

Cause of Death Lobar pneumonia

Contributary Cause of death Typhoid fever

(Sign here) H. N. Gragg. M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7443

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Owyhee

City of DeLamar

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 46

Primary Registration District No. 2123

(No. ....., ... St.)

2. FULL NAME Samuel Whittenberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. April (Month) 7 (Day) 1835 (Year)

7. AGE: 78 Yrs. 9 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER Samuel Whittenberg

11. BIRTHPLACE OF FATHER (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Martha Bartlett

(Address) DeLamar Idaho

15.

Filed ..... 191....

T. D. Farrer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191.....,
that I last saw h.....alive on ..... 191.....,
and that death occured on the date stated above, at 9 29 P.M.

The CAUSE OF DEATH* was as follows:

Mtg. Lues

.....(Duration) ..... Yrs. 5 mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jordan Valley, Ore.,

DATE OF BURIAL: Jan. 28, 1914.

20. UNDERTAKER: John Grete.

ADDRESS: Silver City Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. P
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact
ment of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

County of Bonner Primary Registration District No. 8 05 File No. 7445

City of Laclede (No. ....., ... St.) Registered No. 588

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rufus Graves

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Widowed)

6. DATE OF BIRTH: March (Month) 8 (Day) 1820 (Year)

7. AGE: 93 yrs. 11 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Graves.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Allen
(Address) Laclede

15. Filed May 9 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26 1914, to Feb 28 1914
that I last saw him alive on Feb 28 1914
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. A. Allen M. D.
March 4 1914 (Address) Laclede Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Laclede Cemetery
DATE OF BURIAL: March 3 1914

20. UNDERTAKER: —
ADDRESS:

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 74
Primary Registration District No. 2055
File No. 7441
Registered No. 509

1. PLACE OF DEATH.
County of Boundary
City of Bonners Ferry (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME May Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mongolian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (~~Write the word.~~): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 50 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cooks.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emy Brown
(Address) Sandpoint

15. Filed 4/1 1914 Wm. C. Ruick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ ..... 191..., to March 27 1914, that I last saw h[illegible] alive on March 27 1914 and that death occurred on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Lobar

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Stackhouse M. D.
5/5 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: 4/7 1914

20. UNDERTAKER: E. M. Weaver. — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7446

Name May Young (Chinaman)

Date of Death Mar. 27. 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death

RECEIVED
JUN 10 1914
SECRETARY'S OFFICE
STATE BOARD

(Sign here) C. P. Strackhouse M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Kootenai

Primary Registration District No. 2055

File No. 714

City of Bayview (No. ....., ... St.)

Registered No. 511

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Russell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	English	Married

6. DATE OF BIRTH

March (Month) Twenty-fourth (Day) 1863 (Year)

7. AGE

51 yrs. mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Buxton, Co. of Norfolk, EnG.

10. NAME OF FATHER John Case

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Louisa Harvey

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fredrick P. Russell

(Address) Bayview Idaho.

15.

Filed 4/4 1914 W. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April (Month) — 3 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1914, to Apr. 3 1914, that I last saw h er alive on April 2nd 1914. and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia.

(Duration) — yrs. — mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wang M. D.

4/7 1914 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Athol Ida	Apr 5 1914

20. UNDERTAKER	ADDRESS
E. M. Brown	Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & RDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7449

Registered No. 512

1. PLACE OF DEATH.

Registration District No. 78 Jackson

Primary Registration District No. 2057

County of Bonner

City of Sandpoint (No. ....., N. Douglas St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME C. M. Hacketh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

59 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New Brunswick

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Brower

(Address) Sandpoint Ida.

15. Filed 4/7 1914 Wynn Kinnison Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Mar 1 - 1914, to Apr 5 1914, that I last saw him alive on Apr 5 1914, and that death occurred on the date stated above, at 11. a. M.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

Long time
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Alcoholism
(Secondary)

Lifetime
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Jackson M. D.

19 ..... (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sandpoint | DATE OF BURIAL Apr 8 1914

20. UNDERTAKER E. M. Brower | ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 715
Registered No. 573

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Gordon Kindlow

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec. 19th 1912 (Month) (Day) (Year)

7. AGE: 1 yrs. 3 mos. 22 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sandpoint, Idaho

10. NAME OF FATHER Chas. Skindlow

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Olea Bjorneby

13. BIRTHPLACE OF MOTHER (State or Country) N. Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Skindlow
(Address) Sandpoint, Idaho

15.
Filed May 9 1914 Mmc Kinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1914, to April 10 1914, that I last saw h[illegible] alive on April 10 1914, and that death occurred on the date stated above, at 10A M.

The CAUSE OF DEATH* was as follows:
Pneumonia - Cardeac failure

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Grippe Tuberculosis Otitis media
(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) Mmc Kinnon M. D.
April 10 1914 (Address) Sandpoint

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Kalispell Mont — DATE OF BURIAL: 4/13 1914

20. UNDERTAKER: E. M. Brower — ADDRESS: S P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Jackson.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7451

Registered No. 374

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2055

County of Bonner

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME N. G. Featherby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 59 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E M Brown

(Address) Sandpoint

15. Filed 4/15 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from About Mar 20 1914, to Apr 14 1914, that I last saw him alive on Apr. 10 - 1914, and that death occurred on the date stated above, at 1/9 M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver with ascites -

(Duration) Long time yrs. ..... mos. ..... ds.

Contributory (Secondary) Alcoholism

(Duration) Lifelong yrs. ..... mos. ..... ds.

(Signed) W Jackson M. D.

19 .... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: 4/17 1914

20. UNDERTAKER: E M Brown — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2153

File No. 7453

City of Hope

(No. ....., ... St.)

Registered No. 575

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida May Sisson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH: Nov 11 1854 (Month) (Day) (Year)

7. AGE: 59 yrs. 9 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Janesville Wisconsin

10. NAME OF FATHER: Samuel Gardner

11. BIRTHPLACE OF FATHER (State or Country): Con.

12. MAIDEN NAME OF MOTHER: Camilla Case

13. BIRTHPLACE OF MOTHER (State or Country): Con.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Sisson
(Address) Hope Idaho.

15. Filed 4/21 1914 Mrs. Kinnie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 20 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 12 1914 to Apr 20 1914 that I last saw her alive on Apr 19 1914 and that death occurred on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:
Cancer of Breast

(Duration) 18 yrs. mos. ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Chas S Moody M. D.

19 (Address) Hope Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hope Idaho — DATE OF BURIAL: Apr 21 1914

20. UNDERTAKER: C M Brower — ADDRESS: Hope

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2055
(No. ..... St.)

File No. 7454
Registered No. 517
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Kathern Lakin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH
Dec. 24 1908
(Month) (Day) (Year)

7. AGE
5 yrs. 4 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Emerson Iowa

10. NAME OF FATHER Hal C. Lakin

11. BIRTHPLACE OF FATHER (State or Country) Emerson Iowa

12. MAIDEN NAME OF MOTHER Bella C. Macoy

13. BIRTHPLACE OF MOTHER (State or Country) Shueyville Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bella E. Lakin
(Address) Wrencoe, Ida.

15.
Filed May 11 1914 W. M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Apr 26 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30 1914, to April 26 1914, that I last saw her alive on April 25 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Empyema -

(Duration) ..... yrs. ..... mos. 20 ds.
Contributory (Secondary) Infection from middle ear
Tuberculosis, Measles
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. P. Isaacson M. D.
19 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emerson Iowa	April 28 1914

20. UNDERTAKER	ADDRESS
E. M. Grover	S. P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 877
Primary Registration District No. 2164
File No. 1453
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Midvale (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura E Rodyer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 16 (Day) 91[illegible] (Year)

7. AGE: 31 yrs. 5 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Athena Oregon

10. NAME OF FATHER George Hansell

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Clara May Stafford

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G W Hansell
(Address) Athena

15. Filed Mar 16 1914 — C E Schmuck, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1914, to Mar 15 1914
that I last saw her alive on Mar 15 1914
and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
Septic Infection
..... (Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Placental decay
..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) C E Schmuck M. D.
Mar 16 1914 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale Idaho — DATE OF BURIAL: Mar 15 1914

20. UNDERTAKER: Jas Needham — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5745
Registered No.

1. PLACE OF DEATH.
County of Blaine
City of Arco
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139
(No. ..., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Phillip Mulhall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January (Month) 17 (Day) 1883 (Year)

7. AGE: 31 yrs. ... mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Harness maker
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City, Utah

10. NAME OF FATHER: Charles Mulhall

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Emma Margetts

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. W. Mulhall
(Address) Idaho Falls, Idaho

15. Filed 3/7 1914 Ew Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1914, to March 7 1914, that I last saw h[illegible] alive on March 7 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cardiac insufficency due to mitral regurgitation
(Duration) 3 yrs. ... mos. ... ds.
Contributory (Secondary) Bronchial Pneumonia
(Duration) ... yrs. ... mos. 3 ds.

(Signed) Ew Fox M. D.
3/7/14 19... (Address) Arco Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Idaho
DATE OF BURIAL ... 191...

20. UNDERTAKER: E. T. Peck
ADDRESS: Blackfoot, Ida

YMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 66

Primary Registration District No. 2146

File No. 745

County of Latah

City of Bovill (No. ## St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bosko Molocich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 12 (Month) 25 (Day) 1871 (Year)

7. AGE: 43 Yrs. Mos. 3 ds. 23

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Jack
(b) General nature of industry, business, or establishment in which employed (or employer): Potlatch Lumber Co.

9. BIRTHPLACE (State or Country): Montenegro

10. NAME OF FATHER: Jovan Molocich

11. BIRTHPLACE OF FATHER (State or Country): Montenegro

12. MAIDEN NAME OF MOTHER: Minnie Bitzurich

13. BIRTHPLACE OF MOTHER (State or Country): Montenegro

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Milita Molocich

(Address) Bovill, Idaho.

15. Filed ..... 191.....

F. C. Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/17/1914, to 4/17/1914, that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental. Struck by a falling tree.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. C. Gibson M. D.

4/17/1914 (Address) Bovill, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill, Idaho.

DATE OF BURIAL: 4/18/1914

20. UNDERTAKER: J. L. Shampine

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & ENGS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Custer
City of Mackay
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 109
Primary Registration District No. 2137
(No. ....., ... St.)

File No. 71
Registered No. 10
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Vanous

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	Wh	Married

6. DATE OF BIRTH: 1 (Month) 8 (Day) 1857 (Year)

7. AGE: 56 yrs. 1 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bohemia

10. NAME OF FATHER: Joseph Vanous

11. BIRTHPLACE OF FATHER (State or Country): Bohemia

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wife.
(Address) Mackay Idaho

15. Filed 4/1 1914 F. P. Richards Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/20 1914, to 2/27 1914, that I last saw h[e] alive on 2/24 1914, and that death occurred on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows: —
Chronic Nephritis.

(Duration) Several yrs. mos. ds.
Contributory (Secondary) Acute dilatation Heart
(Duration) P. yrs. mos. 7 ds.

(Signed) F. P. Richards M. D.
2/29 1914 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mackay — DATE OF BURIAL: 2/30 1914

20. UNDERTAKER: C. F. Basler — ADDRESS: Mackay

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1411
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Juliaetta
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Alta Lona Sample

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.
6. DATE OF BIRTH: March 23 1914. (Month) (Day) (Year)
7. AGE: — yrs. — mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Juliaetta Ida.
10. NAME OF FATHER: Clyde C. Sample
11. BIRTHPLACE OF FATHER (State or Country): Iowa.
12. MAIDEN NAME OF MOTHER: Lona M. Curry
13. BIRTHPLACE OF MOTHER (State or Country): Nebraska
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C C Sample
(Address) Juliaetta
15.
Filed April 10 1914 S A Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 9th 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 8th 1914, to April 9. 1914
that I last saw her alive on April 9. 1914
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia with cerebral complications.
..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S A Roe M. D.
4/10 1914 (Address) Juliaetta Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: North Loup, Neb.
DATE OF BURIAL ..... 191...
20. UNDERTAKER: J. Heberer & Son
ADDRESS: Juliaetta Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

78 M c

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7462
Registered No. 487

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
Registration District No.
Primary Registration District No. 2155
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Foley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Aug (Month) 2 (Day) 1899 (Year)
7. AGE: 25 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Republic Mich
10. NAME OF FATHER: Edward Foley
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Johanna Omara
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs E C Brown
(Address): Centralia Wash
15.
Filed Apr 4 1914 M. McClinic
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 16 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1913, to Jan 16 1914
that I last saw him alive on Jan 15 1914
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia

(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Cardiac Dilatation
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) M. McClinic M. D.
Jan 17 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: 2/7 1914
20. UNDERTAKER: E M Brown
ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS. SOISL 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

Jackson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ....., ... St.)

Registration District No. 78
Primary Registration District No. 2105
File No. 7463
Registered No. 788

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Burns

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Brown
(Address) Sandpoint Ida

15.
Filed 2-20 1914 M McKenna
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1913, to Jan 20 1914
that I last saw him alive on Jan 19 1914
and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:
Tuberculous abscess and Tuberculous lungs.

..... (Duration) ..... yrs. 3 mos. — ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Jackson M. D.
Feb. 7 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: Jan 23 1914

20. UNDERTAKER: E M Brown
ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

...ITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
...item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
...should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
...of OCCUPATION is very important. See instructions on back of certificate.

...YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 75
Primary Registration District No. 2105
File No. 7464
Registered No. 489

1. PLACE OF DEATH.
County of Bonner
City of Clarks Fork (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clyde B. Minnick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 25 yrs. 1 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lakesman
(b) General nature of industry business or establishment in which employed (or employer): Logging Train

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: H. A. Minnick

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Frances Rife

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C B Minnick
(Address) Clark Forks

15. Filed 9/10 191 4 W McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 9th (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191....
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Crushing Chest.
R R Accident.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm. Knapp M. D.
2/9 1914 (Address) Hospital Dog Corner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clarks Fork Idaho — DATE OF BURIAL: 2/11 191 4

20. UNDERTAKER: E M Brown — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Eagle
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2155
(No. ....., ... St.)

File No. 746
Registered No. 490
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Meckle M. Hornby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Jan (Month) 7 (Day) 1831 (Year)

7. AGE: 83 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Soldier
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L J Emmett
(Address) Eagle

15. Filed 4-10 1914 M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1913, to Feb 4 1914, that I last saw h[illegible] alive on Feb 4 1914, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:
Carcenoma of Stomach

(Duration) 1 yrs. ..... mos. ..... ds.
Contributory (Secondary): Gastritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.
Feb 19 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Westmond
DATE OF BURIAL: Feb 21 1914

20. UNDERTAKER: [illegible] Brown
ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7466
Registered No. 491

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2153
City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Hearst

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 33 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Mary Peloody

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas E Dolan
(Address) Cabinet, Idaho

15. Filed 4-10 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910 191..., to Feb 23 1914 that I last saw h im alive on Feb 13 1914 and that death occurred on the date stated above, at 1.40 P.M.

The CAUSE OF DEATH* was as follows:
Rupture of aneurism (Thoracic)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. P. Strackhouse M. D.
Feb 21 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL ..... 191...

20. UNDERTAKER: E M Brower
ADDRESS: Sandpoint Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

File No. 746
Registered No. 492
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME P. A. Sandberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1889 (Year)

7. AGE: 24 yrs. 6 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brakeman
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: S. J. Sandberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Emily P[illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Brown
(Address) Sandpoint

15. Filed 3/x 1914 M M Kinsey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: P. P. Accidental Killing by a car turning P.P. [illegible] G.N.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
3-2 1914 (Address) Hope Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn. DATE OF BURIAL: 3/x 1914

20. UNDERTAKER: E M Brown ADDRESS: SP

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ....., ... St.)

Registration District No. 76
Primary Registration District No. 2153

File No. 741
Registered No. 493

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos. Kinnikook

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 28 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: No

11. BIRTHPLACE OF FATHER (State or Country): No

12. MAIDEN NAME OF MOTHER: No

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Brown
(Address) Sandpoint

15. Filed 3/7 1914 M Mackinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental Killed by over turning P.S.P. Bitter. C.M. Pry
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Pancoast M. D.
3-2 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn. DATE OF BURIAL: 3/7 1914

20. UNDERTAKER: E M Brown ADDRESS: S. P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2183
(No. ....., ... St.)

File No. 716
Registered No. 494

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. E. Calhoun

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
35 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Calif.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. Brown
(Address) Sandpoint

15. Filed 3/4 191... M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 2 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental Killing by car
turning R. R. Switch
C. S. N. Ry.
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Ransopp M. D.
3/2 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn — DATE OF BURIAL: 3/2 1914

20. UNDERTAKER: Sandpoint — ADDRESS: Idaho

E. M. Brown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

14-2

Jackson.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ....., ... St.)

Registration District No. 78
Primary Registration District No. 2155

File No. 14
Registered No. 495

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey ~~Glazier~~ Glazier

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 23 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Gray
(Address) R.D. Sdpt.

15.
Filed 4/10 1914 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25 1914, to Mar 4 1914
that I last saw him alive on Mar 4 1914
and that death occurred on the date stated above, at 11-a M.

The CAUSE OF DEATH* was as follows:
Tubercular Meningitis

..... (Duration) ——— yrs. ——— mos. 21 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R T Jackson M. D.
4/7 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: Mar 9 1914

20. UNDERTAKER: C M Brower
ADDRESS: Sandpoint

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

78

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1411
Registered No. 496

1. PLACE OF DEATH.
County of Boundary
City of Sandpoint
(No. ....., ... St.)

Registration District No. 78
Primary Registration District No. 2153

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Seders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1829 (Year)

7. AGE: 85 yrs. 7 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veterinary Surgeon.
(b) General nature of industry business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Chas. Seder.

11. BIRTHPLACE OF FATHER (State or Country): N. J.

12. MAIDEN NAME OF MOTHER: Eliz Anderson

13. BIRTHPLACE OF MOTHER (State or Country): N. J.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Seders.
(Address) .....

15.
Filed 4-10 1914 M. McClinton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1913, to Mar 6 1914, that I last saw h[illegible] alive on Feb 17 1914 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Uraemia
Chronic interstitial
nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Spaeschauer M. D.
Mar 7 1914 (Address) Sandpoint.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn.
DATE OF BURIAL: Mar 8 1914

20. UNDERTAKER: E. M. Bowers.
ADDRESS: Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7471

Name William Leders

Date of Death 8

Cause of Death Uraemia

Contributary Cause of death Chronic Interstitial Nephritis

Uraemia

RECEIVED

JUN 10 1914

SECRETARY'S OFFICE
STATE BOARD OF HEALTH

(Sign here) C. P. Staechouse M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 78

County of Bonner Primary Registration District No. 2155

City of Sandpoint (No. ....., ... St.)

File No. 414

Registered No. 497

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nick Kardelis

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

32 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employer) G.N.R.R. Co

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. M. Knapp Jr.

(Address) Hope Idaho

15.

Filed 4-10 1914 Mac Kenzie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 10th 1914

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,

that I last saw h..... alive on ....., 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Struck by Eng No 178 G.N.R.R. Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Instantly

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Knapp M. D.

March 19 14 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida.	March 11 1914

20. UNDERTAKER	ADDRESS
E. M. Brown	Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 74
Primary Registration District No. 2125
File No. 171
Registered No. 498

1. PLACE OF DEATH.
County of Boundary
City of Sandpoint (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lake P. Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 17 (Day) 1837 (Year)

7. AGE: 76 yrs. 7 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Deceased

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Deceased

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Robinson
(Address) .....

15. Filed Apr 10 1914 M. McKenzie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2 1914, to March 10 1914, that I last saw him alive on March 5 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cordeae Delitatem

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis and Asthma

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McKenzie M. D.

March 11 1914 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 3/17 1914

20. UNDERTAKER: E. M. Brown ADDRESS: S.P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

78

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No. 2155

File No. 7475

County of Bonner

City of Sandpoint (No. , St.)

Registered No. 506

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erik Bergstrom

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: Mar 11 1877 (Month) (Day) (Year)

7. AGE: 37 yrs. mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): Cook

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Otto Bergstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Bergstrom
(Address) Sandpoint

15. Filed 10-4-10 1914 M M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 15 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1914, to March 15 1914 that I last saw h[e] alive on March 15 1914 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M M McKinnon M. D.

March 15 1914 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: Mar 17 1914

20. UNDERTAKER: C M Brower — ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2153

File No. 741

Registered No. 321

County of Bonner

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Theodore Flemming

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 8 (Day) 1914 (Year)

7. AGE: ____ yrs. ____ mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sandpoint Idaho

10. NAME OF FATHER: John F Flemming

11. BIRTHPLACE OF FATHER (State or Country): N. Dak.

12. MAIDEN NAME OF MOTHER: Anne Madeline Dodge

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Flemming
(Address) Sandpoint Ida

15. Filed Mar 10 1914 M M C Kinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1914, to March 19 1914, that I last saw h[illegible] alive on March 18 1914 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Premature birth 6½ mos

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M M C Kinnon M. D.

March 19 14 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 3/19 1914

20. UNDERTAKER: E M Brower ADDRESS: Sandpoint

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2153

File No. 11-1

Registered No. 582

County of Bonner

City of Clark Fork (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Stenstrom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	White	Single (write the word.)

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

32 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed 4-10 1914 M McS Kinnear
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar. 22 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suicide. Strangulation
investigated by myself
as Coroner

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Kennedy M. D.

19.... (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clark Fork	Mar 23 1914
20. UNDERTAKER	**ADDRESS**
C M Brower	Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sagle
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 7153
(No. ....., ... St.)

File No. 7180
Registered No. 585

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane Turnbull

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	Married

6. DATE OF BIRTH
Aug (Month) 31 (Day) 1864 (Year)

7. AGE
49 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Father Williams

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Matilda Carter

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oliver Turnbull
(Address) Sagle, Idaho

15.
Filed 4-10 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1914, to March 30 1914, that I last saw her alive on March 20 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
March 31 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Westmond	Apr 2 1914

20. UNDERTAKER	ADDRESS
C M Brower	Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Jackson.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 71-1

Registered No. 586

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2153

County of Bonner

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie Isabella Dickerson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1907 (Year)

7. AGE: 11 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Child.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: L. E. Dickerson

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Rosana Lancaing

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. Dickerson
(Address) .....

15. Filed 4/10 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 30th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1913, to Mar 30 - 1914; that I last saw her alive on Mar 29 - 1914; and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Rheumatic Endocarditis with Contracted Valves - Mitral the most.

(Duration) 7 yrs. - mos. - ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Jackson M. D.
4/10 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	Apr 1st 1914
20. UNDERTAKER	ADDRESS
E. W. Brown	S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Me.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2155
(No. ....., ... St.)

File No. 782
Registered No. 607
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie May Rifenbery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	Married

6. DATE OF BIRTH
Oct 23 1870
(Month) (Day) (Year)

7. AGE
43 yrs. 5 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Miller

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Rifenbery
(Address) Sand Point Ida

15.
Filed 4/10 1914 M Mc Kinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 31 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1914, to March 30 1914, that I last saw her alive on March 30 1914 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Meningitis Tuberculous

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism + Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M Mc Kinnon M. D.
April 2 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	April 1 1914

20. UNDERTAKER	ADDRESS
E M Brower	Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7482

Name Jessie May Rifenbery

Date of Death Mar. 31, 1914.

Cause of Death Tubercular Meningitis

Contributary Cause of death Not Known

(Sign here) W W McKinnon M.D.

Form [redacted] S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

[redacted] ho
BOA[redacted]LTH
Bureau [redacted]al Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 75 [illegible]

Registered No. [illegible]

County of Ada

City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vicente Lizarralde

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. 3 [redacted] 1868 (Month) (Day) (Year)

7. AGE: 46 yrs. 4 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arriaran Guipuscoa Spain

10. NAME OF FATHER: Pedro Maria Lizarralde

11. BIRTHPLACE OF FATHER (State or Country): Beasain Guipuscoa Spain

12. MAIDEN NAME OF MOTHER: Martina Otaño

13. BIRTHPLACE OF MOTHER (State or Country): Gurnarreta Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jose Lizarralde
(Address) Box 6 Boise Idaho

15.
Filed 3 – 30 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
29 (Month) March (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191..., to ....191...,
that I last saw h....alive on....191...,
and that death occurred on the date stated above, at....M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo Calvert M. D.

19.... (Address)....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: March 31 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7441
Registered No. 6

1. PLACE OF DEATH.
County of Lewis
City of Winchester (No. ....., ... St.)

Registration District No. 48
Primary Registration District No. 2127

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Hasenoehrl

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: — (Month) — (Day) 1852 (Year)

7. AGE: 62 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria Europe

10. NAME OF FATHER: — Hasenoehrl

11. BIRTHPLACE OF FATHER (State or Country): Europe

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos. Rasenoehrl
(Address) Winchester Idaho

15.
Filed 4-8-1914 Ellen J. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
about April 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
— 191..., to — 191...
that I last saw h— alive on — 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suicide by hanging
(verdict as rendered by coroner's jury)
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellen J. Rogers M. D.
4-8-1914 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic
DATE OF BURIAL: 4-9-1914

20. UNDERTAKER: none
ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 7485
Registered No. 38

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lola M. Bell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 29 (Day) 1914 (Year)

7. AGE ..... Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph R. Bell

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary E. Smith

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Rexburg

15. Filed 4-13 1914 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 14 1914, to April 11, 1914, that I last saw h.... alive on Apr. 16 1914 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) Yrs. 7 mos. 25 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Apl. 11 1914 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....
DATE OF BURIAL: 4/13 1914

20. UNDERTAKER John Phillips
ADDRESS Rexburg

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Jefferson

City of Ryburn

Registration District No. 12

Primary Registration District No. 2178

(No. ....., ... St.)

File No. 7486

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Althea Westover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH. June (Month) 17 (Day) 1867 (Year)

7. AGE 51 Yrs. 6 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Wm Rowe

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Elizabeth Swindork

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. D. Westover

(Address) Ryburn Ida.

15. Filed 4-18 1914

G. L. Foster
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 17. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute dellitation

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Thrupe M. D.

4/17 1914 (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ryburn. DATE OF BURIAL Apr 20 1914

20. UNDERTAKER F. M. Williams ADDRESS Ryb.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (b) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*," "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of Kellogg
(No. ....., ... St.)

Registration District No. 100
Primary Registration District No. 2178
File No. 7485
Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Harvey Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 4 (Day) 1899 (Year)

7. AGE: 4 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jas Stewart

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Veda Kirkpatrick

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Stewart
(Address) .....

15. Filed 4-25- 1914
G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10 1914, to 4-24 1914, that I last saw h- alive on 4-24 1914, and that death occured on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:
Bordo Pneumonia

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Measles
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) G G Espe M. D.
1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boston — DATE OF BURIAL: 4/26/1914

20. UNDERTAKER: J M Williams — ADDRESS: Rep

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to the registrar of Vital Statistics)

Death Certificate No. 7488

Name Joseph Harvey Stewart

Date of Death Apr. 24, 1914.

Cause of Death Broncho pneumonia

Contributary Cause of death Measles.

(Sign here) G. L. Espe M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Fremont Primary Registration District No. 2178
City of Parker (No. ..., ... St.)
File No. 7489
Registered No. 42
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Violet Jane Garner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 10 Oclock a.m. April (Month) 24 (Day) 1907 (Year)

7. AGE: 7 yrs. — mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Girl
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salem. Ida

10. NAME OF FATHER: Charles Leroy Garner

11. BIRTHPLACE OF FATHER (State or Country): Clifton Ida

12. MAIDEN NAME OF MOTHER: Rosa Jane Hope

13. BIRTHPLACE OF MOTHER (State or Country): Bluffdale Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm E Hope
(Address): St Anthony. R3. B15. Ida.

15. Filed 4-30 1914 G. L. Eaple Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4/28. 10 Oclock a.m. (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28th 1914, to April 29th 1914, that I last saw her alive on April 28th 1914, and that death occurred on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:
Diabetes

(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Diabetic Coma
(Duration) 24 hrs yrs. mos. ds.

(Signed) J. K. Elmy M. D.
May 29 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 4/30 1914

20. UNDERTAKER: J Rymer — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 7491
Registered No. 44
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie C Koffner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 8 (Day) 1850 (Year)

7. AGE: 63 yrs. 9 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Lars Larsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Kirsta Petersen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lottie Jones
(Address): R F D -3- Rexburg

15.
Filed 5- 9 191X
G L Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5- 3 191X, to 5- 7 191X, that I last saw her alive on 5- 7 191X and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G L Espe M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 7/11 1914

20. UNDERTAKER: J Reynolds
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1000

Primary Registration District No. 2178

File No. 7492

Registered No. 95

1. PLACE OF DEATH

County of Madison

City of Rigby (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Randall

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 8 (Day) 1857 (Year)

7. AGE: 57 yrs. 7 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Seatchell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Bayes

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emily Paul

(Address) Lyman

15. Filed 5-1 1914 G G Cope Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1914, to May 7 1914, that I last saw h[illegible] alive on May 7 1914, and that death occurred on the date stated above, at 7, P. M.

The CAUSE OF DEATH* was as follows:

Sudden death. Probably embolism, or brain haemorrhage

(Duration) ✓ yrs. ✓ mos. ✓ ds.

Contributory (Secondary) Rheumatic fever. duration 1 month. Chronic valvular endocarditis. Indefinite (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Stevenson M. D.

May 9 1914 (Address) Rexburg, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Archer | DATE OF BURIAL: 5/10 1914

20. UNDERTAKER: J Rooney | ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison — Registration District No. 10

City of Bannon — Primary Registration District No. 2178

(No. ..... St.)

File No. 7493

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robt Widdison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Robt. Widdison

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Jane Elizabeth Berry

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt. W. Widdison
(Address) .....

15. Filed 5-9 1914 — G G Epps, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw her alive on 5-8 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H P Shuke M. D.

19.... (Address) Sugar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Sugar — DATE OF BURIAL: 5-10 1914

20. UNDERTAKER: — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7493

Name Robt. Widdison

Date of Death 5-8-14

Cause of Death Dont know cause Child died Without medical aid

Contributary Cause of death Parent Said had a cold

(Sign here) J P Thuper M.D.

(Very probable Broncho-Pneumonia)

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7494

Registered No. 92

1. PLACE OF DEATH.
County of Lemhi
City of Carmen Ida
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Rosegina Thornburg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 23rd (Month) (Day) 1855 (Year)

7. AGE: 58 yrs. 9 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. Carolina

10. NAME OF FATHER: Jackson Best.

11. BIRTHPLACE OF FATHER (State or Country): N Carolina

12. MAIDEN NAME OF MOTHER: Rebeka Grumbly.

13. BIRTHPLACE OF MOTHER (State or Country): N Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Iola Embley
(Address) Salmon Ida,

15. Filed April 19—1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 17th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Hoemorrhage from the Lungs
due to tuberculosis of the Lungs.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Doeble Coroner
3-17 1914 (Address) Salmon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 3-19" 1914

20. UNDERTAKER: W. C. Doeble — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. #1
Primary Registration District No. 2116
(No. ..... St.)

File No. 114
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Guler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Do not know 1
(Month) (Day) (Year)

7. AGE
64 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Quartz Miner
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Peru

10. NAME OF FATHER
Do not know

11. BIRTHPLACE OF FATHER
(State or Country) Do not know.

12. MAIDEN NAME OF MOTHER
Do not know.

13. BIRTHPLACE OF MOTHER
(State or Country) Do not know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Vogler
(Address) Salmon, Idaho

15.
Filed April 26 1914 Helen L Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 25th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Apl 20th 1914, to April 24 1914,
that I last saw him alive on April 24 1914
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 4 20 yrs. ..... mos. ..... ds.
Contributory (Secondary) Cystitis
(Duration) ..... yrs. 7 mos. ..... ds.
(Signed) F L Wright M. D.
4/27 1914 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Salmon Idaho — DATE OF BURIAL 4-26 1914

20. UNDERTAKER W C Hobbs — ADDRESS Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19700

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 749
Registered No. 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Spencer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Married (or Widowed, or Divorced) (Write word.)

6. DATE OF BIRTH
April (Month) 11 (Day) 1856 (Year)

7. AGE
58 yrs. — mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Morton

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Morton

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank N Navemen
(Address) Salmon — Idaho

15.
Filed April 29 1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 2 1914, to Apr 27 1914, that I last saw her alive on Apr 27 1914, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Cardiac asthma
(Duration) about 2 yrs. mos. ds.
Contributory (Secondary) Pulmonary oedema
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Chas. F. Hammond M. D.
4-29 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 4-29-1914

20. UNDERTAKER: W. C. Tolbe — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 749
Registered No. 35

1. PLACE OF DEATH.
County of Lemhi
City of Baker Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Rosetta Rathbun

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH Feb 24 1852
(Month) (Day) (Year)

7. AGE 62 yrs. 3 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Custer Dey

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Abby Low

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Judson Rathbun
(Address) Boke Idaho

15. Filed 5-4 1914 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 2" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1914, to date of death 191, that I last saw h alive on — 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Apoplexy (Second attack)

(Duration) One yrs. mos. ds.
Contributory (Secondary) High blood pressure
(Duration) Several yrs. mos. ds.

(Signed) W. L. Whitwell M. D.
5-4 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery | DATE OF BURIAL 5-4" 1914

20. UNDERTAKER W. C. Loebber | ADDRESS Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Jefferson — Registration District No. 98 — File No. 749

City of Roberts — Primary Registration District No. 2176 — Registered No. 12

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lynn Rolland Slade

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M.	W	

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1912 (Year)

7. AGE: 1 yrs. 5 mos. 2 ds. — IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Washington State

10. NAME OF FATHER Claude Slade

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Pace

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude Slade

(Address) Roberts, Ida

15.

Filed ..... 191... Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1914, to 16 1914, that I last saw h.. alive on April 16 1914 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Enteritis

.....

.....

..... (Duration) ..... yrs. ..... mos. 16 ds.

Contributory (Secondary) Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Melton M. D.

April 16 1914 (Address) Menan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Lyden Wash — DATE OF BURIAL ..... 191...

20. UNDERTAKER: G. A. Hunt — ADDRESS: Ida Falls, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. , St.)

File No. 710
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adrian B. Clinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	married

6. DATE OF BIRTH
Oct. (Month) 9 (Day) 1891 (Year)

7. AGE
22 yrs. 6 mos. 11 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER J. W. Clinger

11. BIRTHPLACE OF FATHER (State or Country) Provo Utah

12. MAIDEN NAME OF MOTHER Josepha Sobell

13. BIRTHPLACE OF MOTHER (State or Country) Provo Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Clinger
(Address) Lorenzo, R. 2 #2

15.
Filed 191 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
4 (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1914, to April 20 1914
that I last saw him alive on 1914
and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Nephritis Chronic
Paroxysmal Hematuria
(Duration) yrs. mos. ds.
Contributory Myocarditis
(Secondary) Acute endocarditis
(Duration) 1 days yrs. mos. ds.
(Signed) G. C. Paxton M. D.
19 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Labelle Ida
DATE OF BURIAL: 4-22 1914

20. UNDERTAKER: S. E. Dunwoody
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7499

Name Adrian B. Clinger

Date of Death 4-20-14

Cause of Death Chronic Parenchymatous Nephritis

Contributary Cause of death Acute Cardiac Dilatation

(Sign here) H C Parker M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 750
Registered No. 10

1. PLACE OF DEATH.
County of Jefferson
City of Rigby R.D. 2
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Clegg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: Apr. 30th (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lyman F. Clegg

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sylvia R. Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lyman Clegg
(Address) Rigby R.D. 2

15. Filed May 10 1914 Ray Stark, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 1st (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 30 1914, to May 1 1914, that I last saw h[er] alive on Apr 30 1914 and that death occurred on the date stated above, at 5a. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Palmer M. D.
Apr. 1914 (Address) Rigby - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milo - Idaho | DATE OF BURIAL: May 1st 1914

20. UNDERTAKER: Friends | ADDRESS: Rigby R.D. 2

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson — Registration District No. 98
City of Ririe R.D.2 (No. ..., ... St.) — Primary Registration District No. 2176
File No. 750
Registered No. 11
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elma Clegg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	Baby.

6. DATE OF BIRTH: Apr. 30 (Month) (Day) 1914 (Year)

7. AGE: ...yrs. ...mos. ...ds. — IF LESS than 1 day how many ...hrs. or ...min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lyman Clegg

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sylvia R. Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lyman Clegg
(Address) Ririe - Ida. R.D.2

15. Filed May 10 1914 — Ray H. Fisher, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 30 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30 1914, to Apr. 30 1914 that I last saw h[illegible] alive on Apr. 30 1914 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ...yrs. ...mos. ...ds.

Contributory (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Chas. Palmer M. D.
May 1 1914 (Address) Ririe - Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milo - Ida. — DATE OF BURIAL: May 1 1914

20. UNDERTAKER: Friends — ADDRESS: Ririe R.D.2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 65

Primary Registration District No. 2145

File No. 7502

County of Latah

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bettie Fletcher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH

April 20 (Month) (Day) 11836 (Year)

7. AGE

77 yrs. 11 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kentuckey

10. NAME OF FATHER William Stephens

11. BIRTHPLACE OF FATHER (State or Country) Kentuckey

12. MAIDEN NAME OF MOTHER Nancy Boyd

13. BIRTHPLACE OF MOTHER (State or Country) Kentuckey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A L Burden

(Address) Garfield

15.

Filed April 6th 1914 D. J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 2 1914 to Apl 2 1914 that I last saw her alive on Apl 2 1914 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul E Wessel M. D.

19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Troy Idaho — DATE OF BURIAL: April 5 1914

20. UNDERTAKER: E Anderson — ADDRESS: Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7511

Registered No. 12

1. PLACE OF DEATH.

Registration District No. 50

Primary Registration District No. 2129

County of Lewis Co.

City of Westlake (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Goldie Edith Denham Steiner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 12 (Day) 1889 (Year)

7. AGE: 24 yrs. 8 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or establishment in which employed (or employer): House wife

9. BIRTHPLACE (State or Country): Missouri Barton Co.

10. NAME OF FATHER: Wm. H. Denham

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Annis Gomez

13. BIRTHPLACE OF MOTHER (State or Country): Indianna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. E. Steiner
(Address) Lewis Co.

15. Filed April 10 1914 H. C. Parrish Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1914, to Mch 29 1914, that I last saw her alive on March 29 1914, and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:
Puerperal Albumenuria & Convulsions

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry B Blake M. D.

Mch 30 1914 (Address) Kentonville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morrow Idaho

DATE OF BURIAL: Apr 1st 1914

20. UNDERTAKER: Harry M West

ADDRESS: Cottonwood Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7501

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Rose Lake

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Eunice Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1911 (Year)

7. AGE 3 Yrs. 7 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Prescott Wash

10. NAME OF FATHER W. Barnett

11. BIRTHPLACE OF FATHER (State or Country) Walla Walla Wash

12. MAIDEN NAME OF MOTHER Mina Waddell

13. BIRTHPLACE OF MOTHER (State or Country) Mo—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Barnett

(Address) Rose Lake Ida

15. Filed May 5 1914 R. D. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Was called and arrived after death 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 3:10 a M.

The CAUSE OF DEATH* was as follows:

Paralysis of Respiratory Centers Caused by the bite of a tick, the tick was discovered 48 hrs. (Duration) before Yes, the ~~ins. death~~ d...

Contributory (Secondary) of Chest

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Winningham M. D.

4/25 1914 (Address) Rose Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Prescott Wash — **DATE OF BURIAL** April 26 1914

20. UNDERTAKER E. W. Wheeler — **ADDRESS** Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 751
Registered No. 10

1. PLACE OF DEATH.
County of Kootenai
City of Carlin Bay:
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Isaac Cowin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.
6. DATE OF BIRTH: Jan (Month) ..... (Day) 1894 (Year)
7. AGE: 22 yrs. 2 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ino.
10. NAME OF FATHER: David Cowin
11. BIRTHPLACE OF FATHER (State or Country): Ind.
12. MAIDEN NAME OF MOTHER: Charity Baker.
13. BIRTHPLACE OF MOTHER (State or Country): Ino.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Cowin
(Address) Carlin Bay Idaho
15. Filed May 5 1914 R. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 4 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 24 1914, to April 4 1914
that I last saw him alive on April 3 1914
and that death occurred on the date stated above, at 12.30 M.
The CAUSE OF DEATH* was as follows: Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 11 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Feeney M. D.
April 4 1914 (Address) Harrison Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida — DATE OF BURIAL: April 5 1914
20. UNDERTAKER: E. W. Wheeler — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7511

Registered No. 9

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of [redacted]atah

City of Harrison

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 126

Primary Registration District No. 2204

(No. .... St.)

2. FULL NAME George Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. [redacted] (Month) 30 (Day) 1847 (Year)

7. AGE: 67 Yrs. ... Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tenn. ~~Dorset/Moor~~

10. NAME OF FATHER Kelop Johnson

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Major Bean
(Address) Harrison Ida

15. Filed May 5 1917 R. S. Jensey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29, 1914, to Apr 3 1914, that I last saw h[redacted] alive on Apr 2 1914, and that death occurred on the date stated above, at 9 a. M.
The CAUSE OF DEATH* was as follows:
Pneumonia with complications

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) General debility

(Duration) ... Yrs. ... mos. ... ds.
(Signed) E. L. Pegen M. D.
19..... (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....da
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: April 6 1917

20. UNDERTAKER: E. W. Wheeler — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7511

Name George Johnson

Date of Death Apr. 3, 1914.

Cause of Death Broncho-pneumonia

Contributary Cause of death Senile debility

(Sign here) E. L. Leger M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 67
Primary Registration District No. 2174
File No. 7512
Registered No. .....

1. PLACE OF DEATH
County of Ada
City of Boise
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank J Moore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1901

7. AGE: 13 Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Dan Moore

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: B, Gray

13. BIRTHPLACE OF MOTHER (State or Country): Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): John V. Alley
(Address): Boise, Ida.

15.
Filed 4-5-1914 John V. Alley Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26 1914, to May 4 1914, that I last saw h.. alive on May 4 1914, and that death occured on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Acut. Rheu
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John V. Alley M. D.
4-5 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ~~..... days~~ In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Boise

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: Apr 6 1914

20. UNDERTAKER: C Nasser
ADDRESS: Lewiston

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7512

Name Frank Moore

Date of Death Apr. 4, 1914.

Cause of Death Pneumonia Crupous

Contributary Cause of death Not Known

(Sign here) J Lee McAlley M.D.

SEP 28 1914

SECRETARY'S
STATE BOARD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 63

County of Latah

Primary Registration District No. 2143

File No. 751

City of Near Kendrick (No. ....., ... St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena Hulda Clara Swanson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH: 3 (Month) 12 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 31 ~~28~~ ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Near Kendrick Ida

10. NAME OF FATHER: Axel Swanson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lena Brown

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Axel Swanson
(Address) Kendrick Ida

15. Filed April 14 1914 J E Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1914, to April 12 1914, that I last saw h.r alive on April 8 1914, and that death occurred on the date stated above, at 6 9 M.

The CAUSE OF DEATH* was as follows:

Spina bifida

(Duration) ..... yrs. ..... mos. 31 ds.

Contributory (Secondary): none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Hoyt M. D.

May 1 1914 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wild Rose Cemetery	Apr 14 1914

20. UNDERTAKER	ADDRESS
none	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 751
Registered No.

1. PLACE OF DEATH.
County of Benewah
City of Kamiah (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm M Crowley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not Known (Month) (Day) 1 (Year)

7. AGE: 57 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O E Mayer
(Address) Kamiah

15.
Filed May 8 1914 W. H. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 3 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. C. Parish Coroner M. D.
May 4 1914 (Address) Kamiah, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery
DATE OF BURIAL: May 9 1914

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 91
Primary Registration District No. 2168
File No. 751
Registered No. 16

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Malinda Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Caucasian	Married

6. DATE OF BIRTH
1808 (Month) 1 (Day) (Year)

7. AGE
96 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Nelson
(Address) Orofino Idaho

15. Filed May 1 1914 J. M. Fairy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 7th. 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1912, to March 7 1914, that I last saw h[er] alive on March 6 1914, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Old Age

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) John Nelson M. D.

Mar 8 1914 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Orofino | DATE OF BURIAL May 3 1914

20. UNDERTAKER W. L. Stoddard | ADDRESS Gifford Ida.

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 751.
Registered No. 17
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah M. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: 1857 (Month) 1 (Day) (Year)

7. AGE: 57 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Williams
(Address) Orofino. Idaho

15. Filed May 30 1914 J. M. Fairley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 9th. (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1912, to March 9 1914 that I last saw her alive on March 9 1914 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Organic heart disease

(Duration) 9 yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) John Williams M. D.
March 9 1914 (Address) Orofino. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nez Perce. DATE OF BURIAL: May 1 1914

20. UNDERTAKER: W. Stoddard ADDRESS: Gifford, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 151
Registered No. 18
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest Ulbright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Caucasian	Married Widower

6. DATE OF BIRTH
1839 (Month) 1 (Day) (Year)

7. AGE
75 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Saloon keeper
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Olsinens
(Address) Orofino, Idaho

15.
Filed May 1 1914 J. M. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 14th. 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3rd. 1914, to March 14th 1914, that I last saw h sm alive on March 14th 1914, and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) 2 yrs. 7 mos. 9 ds.

Contributory (Secondary) Insanity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Olsinens M. D.
May 4 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Spokane
DATE OF BURIAL: ✓ 191..

20. UNDERTAKER: Harry Suters
ADDRESS: Spokane

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 76
Primary Registration District No. 2768
(No. ....., ... St.)

File No. 751
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hugh Davidson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Caucasian	Single

6. DATE OF BIRTH
1879 (Month) 1 (Day) (Year)

7. AGE
35 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Givens
(Address) Orofino. Idaho

15.
Filed May 1 1914 J. M. Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 22nd. 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 28 1914, to March 22 1914, that I last saw him alive on March 22 1914, and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) 9 yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) John Givens M. D.
Mar 23 1914 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE ~~OF BURIAL OR~~ REMOVAL	DATE OF BURIAL
Lewiston	..... 191...

20. UNDERTAKER	ADDRESS
W. A. Shaw.	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 40

Primary Registration District No. 2168

File No. 751

County of Clearwater

City of Lenore (No. ....., ... St.)

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME A. B. Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH

June (Month) 22 (Day) 1858 (Year)

7. AGE

56 yrs. 9 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) Farm Work

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Sam Fankenthall

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER Fankenthall

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. B. Larson

(Address) Lenore

15. Filed May 1 1914 J. M. Travis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr. (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1914, to April 19 1914, that I last saw h[illegible] alive on April 19 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Injured Head

..... (Duration) 1 yrs. 1 mos. ..... ds.

Contributory (Secondary) Conjestion

..... (Duration) - yrs. 1 mos. ..... ds.

(Signed) J. M. Travis M. D.

May 1 1914 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lenore	Apr 22 1914
20. UNDERTAKER	ADDRESS
P. C. Stoddard	

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Fraser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 7168
(No. ....., ... St.)

File No. 752
Registered No. 21
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orval McKinney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Oct (Month) 19 (Day) 1909 (Year)

7. AGE: 5 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Fred McKinney

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lou

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Smith
(Address) .....

15. Filed May 1 1914 J. M. Faris Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1914, to Apr 5 1914, that I last saw him alive on Apr 5 1914 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Sudden heart failure — cause certificate incomplete dilated heart + chronic interstitial nephritis following acute articular Rheumatism
(Duration) ..... yrs. 2 mos. ..... ds.
Contributory (Secondary) Acute Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle D. Norwood M. D.
19 ..... (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fraser — DATE OF BURIAL: Apr 7 1914

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

Primary Registration District No. 2001

File No. 1752

Registered No. 6

County of Ada

City of Star.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nora Pollard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Nov (Month) 26 (Day) 1887 (Year)

7. AGE: 26 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Hailey Idaho

10. NAME OF FATHER: O. P. Wisdom

11. BIRTHPLACE OF FATHER (State or Country): Indeo mo

12. MAIDEN NAME OF MOTHER: Melvina Potter

13. BIRTHPLACE OF MOTHER (State or Country): Montgomery Co Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. P. Pollard
(Address) Star Ida

15. Filed Apr 1 1914 — O. C. Hall, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 1 (Month) (Day) 1914 (Year) — 31 10-4V

17. I HEREBY CERTIFY, That I attended deceased from March 31 1914, to March 31 1914, that I last saw h[illegible] alive on March 31 1914, and that death occured on the date stated above, at 10:45 P. M.

The CAUSE OF DEATH* was as follows:
Convulsion during child birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Unascertainable Kidneys.

Duration ..... yrs. ..... mos. ..... ds.

(Signed) John Boeckel M. D.

Apr 1 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary — DATE OF BURIAL: Apr 3 1914

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of near Star

Registration District No. 10

Primary Registration District No. 2001

(No. ....., ... St.)

File No. 17523

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances W. Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 19 (Day) 1845 (Year)

7. AGE: 68 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John Wilson

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene F. Gray.

(Address) Eagle R.F.D. 1

15.

Filed Apr 14 1914 [illegible]

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1914, to April 11th 1914, that I last saw h[illegible] alive on April 11th 1914, and that death occured on the date stated above, at 10, 45 P.M.

The CAUSE OF DEATH* was as follows:

Mucous Colitis

(Duration) ..... Yrs. ..... mos. 28 ds.

Contributory (Secondary) Uremia & Chronic Bright's Disease unknown to deponent

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M.D. Morris M.D.

4/12 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: Apr 13 1914

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of Certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7524

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Parma

Registration District No. 3

Primary Registration District No. 2007

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Karn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 17 (Day) 1906 (Year)

7. AGE: 7 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: E. B. Karn

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Katherine Naftzger

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E B Karn

(Address) Parma Idaho - R.F.D. # 1.

15.

Filed April 27 — 1914

F. A. Schmidt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30 1914, to April 27 1914, that I last saw her alive on April 27 1914, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Appendiceal Abscess

(Duration) ..... Yrs. 2 mos. 27 ds.

Contributory (Secondary) Subphrenic Abscess

(Duration) ..... yrs. same (2) mos. ..... ds.

(Signed) Chas. B. Allen M. D.

4-28-1914 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rowell Cemetery — DATE OF BURIAL: Apr 29 1914

20. UNDERTAKER: Platt Peckham Co — ADDRESS: Parma

BYMB - YORK CO., PTRS. & SONS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1007
(No. .... St.)

File No. 7525
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
~~City~~ Town of Parma

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Lee Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 18 (Day) 1866 (Year)

7. AGE: 47 Yrs. 47 Mos. 26 ds. (47 5/30)

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Chas E. Davis

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Betty B. North

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. G. Davis
(Address) North Yakima Wash.

15. Filed April 19 1914 T. A. Schmick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1914, to April 14 1914, that I last saw him alive on April 14 1914, and that death occured on the date stated above, at 8-35 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
.....
.....
(Duration) — Yrs. — mos. 6 ds.

Contributory (Secondary) .....
(Duration — yrs. — mos. — ds.

(Signed) Hilligan E. Baldwin M. D.
19..... (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? At Place of death
Former or usual residence Not Known

19. PLACE OF BURIAL OR REMOVAL: Parma Ida — DATE OF BURIAL: 4/16 1914

20. UNDERTAKER: Platt Peckham Co — ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BKRS. 24654

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7525

Name Robert Lee Davis

Date of Death Apr. 14, 1914.

Cause of Death Lobar pneumonia

Contributary Cause of death None

(Sign here) W. V. Medford M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Parma

Registration District No. 3

Primary Registration District No. 1007

(No. ....., ... St.)

File No. 7592

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah E. Strain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wid

6. DATE OF BIRTH. Feb (Month) 25 (Day) 1864 (Year)

7. AGE: 50 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. L. Andrews

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Margaret McConnell

13. BIRTHPLACE OF MOTHER (State or Country): Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) J. S. Strain

15. Filed May 1- 1914 F. A. Schmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1- 1914, to April 30 1914, that I last saw h.. alive on April 27- 1914, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Anaemia, Tuberculosis & Syphilis Causing Scattered Fatty Degeneration of Heart & Vertebrae

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Schmidt M. D.

4/30-1914 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma Idaho — DATE OF BURIAL: 5-2-1914

20. UNDERTAKER: Platt Beckham Co — ADDRESS: Parma

D. H. Kellar

WRITE PLAINLY, WITH [illegible] PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
File No. 7527
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Parma
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Queene Fritz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 3 (Day) 1838 (Year)

7. AGE: 76 Yrs. ___ Mos. 2 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Polly Fox

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. D. Pitt
(Address) Parma Ida

15. Filed May 4 1914 F. A. Schmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1914, to May 3 1914, that I last saw h alive on May 3 1914, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Senility
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Bronchitis
(Duration 20 yrs. ____ mos. ____ ds.
(Signed) F. A. Schmidt M. D.
5-3 1914 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____yrs ____mos ____days. In the State ____yrs ____mos ____days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Caldwell Valley — DATE OF BURIAL: 5-5-1914

20. UNDERTAKER: Platt Cleveland — ADDRESS: ____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of —
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 81
Primary Registration District No. 2158
(No. ——, —— St.)

File No. 752
Registered No. 3
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mike Maio

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Don't know (Month) (Day) 1849 (Year)

7. AGE: 65 yrs. ? mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Frank Maio

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Annie Maccarattor

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James Russell
(Address) Priest River

15.
Filed April 22 1914 E S McCarty
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1914, to April 21 1914 that I last saw him alive on April 21 1914, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) — yrs. — mos. 15 hrs. da.

Contributory (Secondary) Arterio Sclerosis
(Duration) — yrs. — mos. — ds.

(Signed) E Dunton McCarty M. D.
April 21 1914 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River
DATE OF BURIAL: April 22 1914

20. UNDERTAKER
ADDRESS

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Bonner Primary Registration District No.
City of — (No. —, St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 752
Registered No. 2
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Timothy Donavan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Don't Know

6. DATE OF BIRTH: Don't Know (Month) 1 (Day) (Year)

7. AGE: about 65 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs.or* ..... *min.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Gall
(Address) Newport Wash

15. Filed April 9 1914 E D McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1914 to April 9 1914 that I last saw him alive on April 1e 1914, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Acute Gastritis
Heart Failure
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Gastric ulcer, Senile
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. Stoneberg M. D.
April 9 1914 (Address) Newport Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River Ida. DATE OF BURIAL: April 20 1914

20. UNDERTAKER: G R Bloss ADDRESS: Rathdrum Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

original

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 755

Registered No. 4

1. **PLACE OF DEATH.**

County of Bonner

City of Thama

Registration District No.

Primary Registration District No.

(No. near Thama St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. **FULL NAME** alonzo Coale

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** male

4. **COLOR OR RACE** white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (*Write* the word.) married

6. **DATE OF BIRTH** March 9 1862
(Month) (Day) (Year)

7. **AGE** 52 yrs. — mos. 16 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *min.*

8. **OCCUPATION**
(a) Trade, profession or particular kind of work R.R. Engineer
(b) General nature of industry business or establishment in which employed (or employer) G.N. Ry

9. **BIRTHPLACE** (State or Country) California

10. **NAME OF FATHER** Jacob L. Coale

11. **BIRTHPLACE OF FATHER** (State or Country) New York

12. **MAIDEN NAME OF MOTHER** Jennie Garvin

13. **BIRTHPLACE OF MOTHER** (State or Country) New York

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs Cydia Coale
Fred W. Dreier
(Address) 719 Indiana Ave Spokane
Priest River Idaho

15.
Filed April 23 1914 E. S. McCarty
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**
March 25 1914
(Month) (Day) (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from ——— 191..., to ——— 191...
that I last saw him alive on March 25 1914,
and that death occurred on the date stated above, at 3 30p M.

The **CAUSE OF DEATH*** was as follows:
Killed in wreck collision
Train 44 and Extra Freight 733

——— (Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ———

——— (Duration) ... yrs. ... mos. ... ds.

(Signed) Fred W. Dreier M. D.
Mch 25 1914 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Spokane Wn

DATE OF BURIAL ... 191...

20. **UNDERTAKER** Smith & Co

ADDRESS Spokane

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Original

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17531

Registered No. 92

1. PLACE OF DEATH. Registration District No. 81

County of Bonner Primary Registration District No. 2158

City of Thama, Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. F. Decker.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 30 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Messenger @ R.N. R.R.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: do

11. BIRTHPLACE OF FATHER (State or Country): do

12. MAIDEN NAME OF MOTHER: do

13. BIRTHPLACE OF MOTHER (State or Country): do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred K. W. Didier M.D.
(Address) Priest River. Idaho

15.
Filed April 23 1914 E. W. McCarley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 25, 1914. 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 3.30p M.

The CAUSE OF DEATH* was as follows:

Killed in wreck; collision train No. 44 and Extra Freight No. 733

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred K. W. Didier M. D.
March 25 1914. (Address) Priest River. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burlington Wash. DATE OF BURIAL ..... 191...

20. UNDERTAKER: Smith & Co. ADDRESS: Spokane. Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2086
(No. ....., ... St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7532
Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gillie A. Calvin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widowed
6. DATE OF BIRTH: June 1st. (Month) (Day) 1843 (Year)
7. AGE: 70 yrs. 10 mos. 25 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min?*
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Ky.
10. NAME OF FATHER: John Carr
11. BIRTHPLACE OF FATHER (State or Country) Ky.
12. MAIDEN NAME OF MOTHER: Mary Woldrige
13. BIRTHPLACE OF MOTHER (State or Country) Ky.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Carr
(Address) May, Ida.
15.
Filed April 27 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 26, 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 23 1914, to April 26, 14 191.. that I last saw h er alive on April 26, 14 191.. and that death occurred on the date stated above, at 5.40 P M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of lungs
(Duration) 40 yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 6 ds.
(Signed) ..... M. D.
4/27 1914 (Address) Challis, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Challis — DATE OF BURIAL: 4/29 1914
20. UNDERTAKER: Friends — ADDRESS: Challis.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7533
Registered No. 70

1. PLACE OF DEATH.
County of Custer
City of Challis

Registration District No. 14
Primary Registration District No. 2061
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isabella S. Hallenan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed
6. DATE OF BIRTH: Mar. 3 (Month) (Day) 1839. (Year)
7. AGE: 75 yrs. 1 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): La.
10. NAME OF FATHER: Daniel S. Devores
11. BIRTHPLACE OF FATHER (State or Country): Pa.
12. MAIDEN NAME OF MOTHER: Eleanor Clark.
13. BIRTHPLACE OF MOTHER (State or Country): [illegible] La.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Kirke,
(Address) Challis
15.
Filed April 20 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 19 (Month) (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 9 1914, to Apr 19 1914
that I last saw h-e-s alive on Apr 19 1914
and that death occurred on the date stated above, at 10.30 p M.
The CAUSE OF DEATH* was as follows:
Apoplexy
..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Paralysis
..... (Duration) 4 yrs. ..... mos. ..... ds.
(Signed) J. W. Kelley M. D.
Apr 20 1914. (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Challis
DATE OF BURIAL: 4/21 1914
20. UNDERTAKER: J. W. Kelley & Friends
ADDRESS: Challis

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7531

Registered No. 68

1. PLACE OF DEATH.
County of Custer
City of Challis

Registration District No. 14
Primary Registration District No. 2061
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth Wayne Williamson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb 13 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Clyde Williamson

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Amelia Marker

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde Williamson
(Address) Challis

15.
Filed April 17 1914
L. Kistler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 15 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1914, to Apr 15 1914
that I last saw him alive on Apr 15 1914
and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
Heart Failure

..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Kelley M. D.
Apr 16 1914 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Challis, Ida.
DATE OF BURIAL: April 17 1914

20. UNDERTAKER: Friends
ADDRESS: Challis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 753
Registered No. 69

1. PLACE OF DEATH.
County of Custer
City of Challis (No. ....., ... St.)

Registration District No. 14
Primary Registration District No. 2061

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Letitia Violet Bradford

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (write the word.)

6. DATE OF BIRTH
..... (Month) ..... (Day) 1870 (Year)

7. AGE
44 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) New York

10. NAME OF FATHER
Decatur

11. BIRTHPLACE OF FATHER
(State or Country) New York

12. MAIDEN NAME OF MOTHER
Do not know

13. BIRTHPLACE OF MOTHER
(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. H. Bradford
(Address) Challis, Ida.

15.
Filed 4/18 1914
C. T. Whitney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 16th. 14 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9th. 1914, to April 9,14 191
that I last saw her alive on April 16-14 191
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute Uraemia (paralytic form)

..... (Duration) ..... yrs. ..... mos. 6 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. T. Whitney M. D.
4/18 1914 (Address) Challis, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Challis, Ida.
DATE OF BURIAL: 4/18 191

20. UNDERTAKER: Friends
ADDRESS: Challis.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. 75

County of

City of Burley (No. , St.)

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 31 (Day) 1913 (Year)

7. AGE: yrs. 3 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... At home
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Burley Ida.

10. NAME OF FATHER Edward Nelson

11. BIRTHPLACE OF FATHER (State or Country) Bearlake Co Ida

12. MAIDEN NAME OF MOTHER Ema E Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Bingham Co Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Nelson

(Address)

15. Filed Apr. 7 1914 Burley Ida. W. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 6th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30th 1914, to April 6th 1914, that I last saw h alive on April 5th 1914, and that death occurred on the date stated above, at 1:30 PM.

The CAUSE OF DEATH* was as follows:

Broncho- Pneumonia

(Duration) yrs. mos. 12 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.

4-6 1914 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: April 7 1914

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

File No. 753

City of Burley

(No. ....., ... St.)

Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucynthia Robbins

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Widowed

6. DATE OF BIRTH: May (Month) 22 (Day) 1869 (Year)

7. AGE: 72 yrs. 10 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Thomas Nevada

10. NAME OF FATHER: Chas W. Hubbard

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Mary Edwards.

13. BIRTHPLACE OF MOTHER (State or Country): Wales England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florida Robbins

(Address) Burley Idaho

15. Filed Apr 6th 1914 Reg. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 6th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910 191.., to April 6th 1914, that I last saw h.. alive on April 6th 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Trouble

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary) Paralytic Stroke

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

4-6-1914 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Ida	April 8 1914
20. UNDERTAKER	ADDRESS
L. B. Gallogly	Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia — Registration District No. 117

City of Burley — Primary Registration District No. 2196

(No. ....., ... St.)

File No. 753

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nora Allen Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 12 (Day) 1913 (Year)

7. AGE: ..... yrs. 1 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Custer Co. Ida.

10. NAME OF FATHER: James Baker

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Bettie Akers

13. BIRTHPLACE OF MOTHER (State or Country): Custer Co. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Baker
(Address) Burley Idaho

15. Filed April 8th 1914 — Dr. J. C. Patterson, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3rd 1914, to April 7th 1914, that I last saw h[illegible] alive on April 7th 1914, and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) Measles, Whooping Cough

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

4-8 1914 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. — DATE OF BURIAL: April 9 1914

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 754
Registered No. 25

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby McClendon.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 27 (Day) 1913 (Year)

7. AGE: ..... yrs. 4 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Burley, Cassia Co. Ida.

10. NAME OF FATHER: Leburn McClendon

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Maud Trees

13. BIRTHPLACE OF MOTHER (State or Country): Colorado.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. T. Trees
(Address): Burley Idaho

15.
Filed April 3rd 1914 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: ~~March~~ April 1st 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31st 1914, to April 1st 1914, that I last saw he alive on March 31st 1914, and that death occurred on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Whooping Cough

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) J. C. Patterson M. D.

4-2 1914 (Address) Burley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: April 2. 1914

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-1944

CERTIFICATE OF DEATH.

Registration District No. 47
Primary Registration District No. 174

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7541
Registered No. 24

1. PLACE OF DEATH.
County of Cassia
City of Burley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucius Hubbard Judd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb — 1858 (Month) (Day) (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Hiram Judd

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Lizanie Fuller

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Burley

15. Filed April 11th 1914 Dr. J. C. Patterson Local Registrar

BYNS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1st 1914, to Apr. 11th 1914, that I last saw him alive on Apr. 10th 1914, and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Tuberculosis of Lungs
(Duration 5 yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
April 11 1914 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. — DATE OF BURIAL: 4/17 1914

20. UNDERTAKER: A. L. Nash — ADDRESS: Burley

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7541

Name Lucius Hubbard Judd

Date of Death Apr. 11, 1914

Cause of Death Lobar Pneumonia

Contributary Cause of death Tuberculosis of Lungs

(Sign here) J. C. Patterson M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 2012
File No. 751
Registered No. 30

1. PLACE OF DEATH.
County of Idaho.
City of N. Meadows.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John T. Merritt.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 22 (Day) 84? (Year)

7. AGE: 66 yrs. 1 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber-man.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: William Merritt.

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Martha Sides

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Delia Merritt (wife)
(Address) N. Meadows.

15.
Filed 4-9- 1914 Frank Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 6. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 3 1913; to April 6 1914, that I last saw h[im] alive on April 6. 1914 and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH was as follows:*
Mitral Regurgitation
Broken Compensation

(Duration) 2 yrs. 5 mos. ? ds.
Contributory Exhaustion
(Secondary)
(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Robt. L. McLean M. D.
4/8 1914 (Address) N. Meadows.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meadows-Idaho. DATE OF BURIAL: 4/9/14 191...

20. UNDERTAKER: None Available ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

Primary Registration District No. 2012

File No. 754

County of Adams

City of N. Meadows (No. 0, St.)

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Judy Latham

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: April (Month) 30 (Day) 1873 (Year)

7. AGE: 9 yrs. 11 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: — Rodes

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Unascertained

13. BIRTHPLACE OF MOTHER (State or Country): Unascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lee Clarke (daughter) Mrs
(Address) N. Meadows Ida

15.
Filed 4-9- 1914 Frank E. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/2/14 191 , to 4/6/14 191 , that I last saw h[illegible] alive on 4/7/14 191 , and that death occurred on the date stated above, at 5:10 A M.

The CAUSE OF DEATH* was as follows:
Senility.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) R. W. Meacan M. D.

4/8/14 19 (Address) N. Meadows Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oregon — DATE OF BURIAL: 4/10/14 191

20. UNDERTAKER: None Available — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7544

Registered No. 52

1. PLACE OF DEATH.

County of Adams

City of Goodrich

Registration District No. 4

Primary Registration District No. 201

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 10 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas Hulsenkamp Sr.

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Rosie Henson Hulsenkamp

13. BIRTHPLACE OF MOTHER (State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde Ed Watson

(Address) Council Ida.

15. Filed Ap 12 1914 Frank V. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1914, to April 11 1914, that I last saw h... alive on April 10 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Imperforate anus.

Malformation of Penis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde Ed Watson M. D.

Ap 11 1914 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Goodrich | DATE OF BURIAL: 4-11 1914

20. UNDERTAKER: none Family Neighbors | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1
Primary Registration District No. 20 11
(No. ..... St.)
File No. 754
Registered No. 5-3

1. PLACE OF DEATH.
County of Adams
City of Indian Valley
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eloise Josephine Leach

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 2 (Month) 25 (Day) 1914 (Year)

7. AGE: Yrs. 2 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Adams Co- Idaho.

10. NAME OF FATHER Thomas Leach

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clyde E Watson
(Address) Council

15. Filed 5-3 1914 Frank E Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Died while nursing the breast.
Cause - Chronic Valvular disease of heart- from history of case.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Watson M. D.
4/29 1914 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: 4-30 1914

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Samaria
(No. ..... St.)

Registration District No. 26
Primary Registration District No. 2069
File No. 754
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David James Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (or Wid.)

6. DATE OF BIRTH.
Oct (Month) 11 (Day) 1877 (Year)

7. AGE
36 Yrs. 5 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Samaria

10. NAME OF FATHER Lewis Hughes

11. BIRTHPLACE OF FATHER
(State or Country) Wales

12. MAIDEN NAME OF MOTHER Mary Ann Davis

13. BIRTHPLACE OF MOTHER
(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lewis Hughes
(Address) Samaria

15.
Filed 3-30 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar. (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/25 1914, to 3/28 1914
that I last saw h im alive on 3/28/ 1914
and that death occured on the date stated above, at 10:30 M.
The CAUSE OF DEATH* was as follows:
Inflammation of Intestines

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Rupture of Abomit

(Duration) yrs. mos. 2 ds.
(Signed) J. M. Evans M. D.
3/30 1914 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria Ida. DATE OF BURIAL: Mar 31 1914

20. UNDERTAKER: H. S. Johnson ADDRESS: Malad Ida

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FRYINGMANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STAR - PRINT CO., PTBS. & BKBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

File No. 754
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Oneida
City of Samaria

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane R. Hughes

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov. (Month) 6 (Day) 1913 (Year)

7. AGE
Yrs. 5 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Samaria Ida

10. NAME OF FATHER: David Hughes

11. BIRTHPLACE OF FATHER (State or Country): Samaria Ida

12. MAIDEN NAME OF MOTHER: Elizabeth A. Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Samaria Ida

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) David Hughes
(Address) Samaria Ida

15. Filed 4-2 1914 — D C Ray, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 29 1914, to Mch 31 1914, that I last saw h. alive on Mch. 30 1914, and that death occured on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Exhaustion
(Duration) Yrs. 3 mos. ds.
Contributory (Secondary) Rupture of stomach
(Duration yrs. mos. ds.

(Signed) D C Ray M. D.
4-2 1914 (Address) Malad City Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria — DATE OF BURIAL: April 2 1914

20. UNDERTAKER: D. E. Johnson — ADDRESS: Malad Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 754
Registered No. 22

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Neal.

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. J. Mowery
(Address) Wallace Ida.

15. Filed Apr 4 1917 H. Leo Zumpe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 2 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1917 to Apr 2 1917, that I last saw him alive on Apr 2 1917, and that death occured on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(Duration) Yrs. 2 mos. 5 ds.

Contributory (Secondary) Exposure

(Duration) yrs. ..... mos. ..... ds.

(Signed) D. J. Mowery M.D.

4/4 1917 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Apr 5 1917

20. UNDERTAKER: Wards Undertaking Co. — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 755

Registered No. 24

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stefi Zubooski

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Oct (Month) 23 (Day) 1911 (Year)

7. AGE: 2 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mullan Idaho

10. NAME OF FATHER: Mikael Zubooski

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Julia Oelk

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mike Zubooski

(Address) Burke Idaho

15. Filed April 4 1914 T. Lee Zinn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1914, to April 3 1914, that I last saw him alive on April 3 1914 and that death occured on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows: Diphtheria Laryngitis

(Duration) ..... Yrs. 1 day ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Howard M. D.

4/3 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho

DATE OF BURIAL: April 4 1914

20. UNDERTAKER: Bruce Worstell

ADDRESS: Wallace Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7551

Registered No. 25

1. PLACE OF DEATH.

County Shoshone

City of Wallace Ida

Registration District No. 70

Primary Registration District No. 10 11

(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Hoolihan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1872

7. AGE: 42 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Shamokin Penn

10. NAME OF FATHER: Hugh Hooling

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Brennan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Larry Hooling

(Address) [redacted] Ran.

15. Filed April 7 1914 A. Leo Linde Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) – 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1913, to April 6 1914 that I last saw h[illegible] alive on April 5 1914 and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

1 (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Mowery M. D.

April 7 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mullan Idaho — DATE OF BURIAL: April 9 1914

20. UNDERTAKER: Ward's Undertaking Co — ADDRESS: Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1011 — 70
Primary Registration District No. 1011
File No. 755
Registered No. 26

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. W. Lax

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: 84 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner pre-
(b) General nature of industry, business, or establishment in which employed (or employer): viously.
9. BIRTHPLACE (State or Country): New Hampshire
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) ..... M. C. Howard
(Address) ..... Wallace Ida.
15. Filed Apr 9 1914 H. Leo Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 9 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1914, that I last saw h alive on Apr 8 1914, and that death occured on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows:
Small Pox
..... (Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Old age
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. C. Howard M. D.
(Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho — DATE OF BURIAL: 4/9 1914
20. UNDERTAKER: Ward U. Leo — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. #C 7011
File No. 7553
Registered No. 27

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Penn St. Wallace St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. Phillips,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed
6. DATE OF BIRTH. April (Month) 25 (Day) 1856 (Year)
7. AGE: 58 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: not given
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miss Estella Phillips
(Address) Wallace Idaho
15. Filed 4/13 1914 T. Lee Zimmerman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1914 (Year)
17. I ~~HEREBY~~ CERTIFY, That I attended deceased from October 1913, to April 12 1914, that I last saw h~~im~~ alive on April 12 1914 and that death occured on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Hypertrophic Cirhosis Liver
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) D. R. Mowery M. D.
4/13 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Nash — DATE OF BURIAL: Apr 14 1914
20. UNDERTAKER: Bruce & Nostad — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
(No. Bureau Vital Statistics Wallace)
File No. 7554
Registered No. 29

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dominick Oro

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
35 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER John Oro

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Mary Gabel

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Oro
(Address) Wallace Ida

15.
Filed 4/14 1914
H. Leo Trump
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on 1914
and that death occured on the date stated above, at about 6 P.M.

The CAUSE OF DEATH* was as follows:
Drilled into missed hole
Premature explosion-accidental
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) D. McGarry M. D.
April 13 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Idaho	Apr 14 1914
20. UNDERTAKER Bruce G Wootten	ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Shoshone
City of Wallace
(No. ....., ... St.)

Registration District No. 70
Primary Registration District No. 1 011

File No. 755
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH. Oct (Month) 10 (Day) 1837 (Year)

7. AGE 76 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER Issac Hill

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Sarah Smart

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary McDonald
(Address) Wallace Ida

15.
Filed 4/16 1914 F. Leo Dunlay
Local Registrar

SYMS - YORK CO., PTRS. & BOOS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1914, to April 14 1914, that I last saw h[illegible] alive on April 13 1914 and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
April 16 1914 (Address) St. Leo Dunlay

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: April 17 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)
File No. 7556
Registered No. 30

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Sandeel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Unknown (Month) 1 (Day) (Year)

7. AGE: 50 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Thompson
(Address) Wallace Idaho

15. Filed 4/20 1914 T. L. Livingston Local Registrar

STUB - YORK CO., PTG. & BKB. 24068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 15 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1914 to Apr 15 1914
that I last saw h[illegible] alive on Apr 15 1914
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) T. Leo Sweeney M. D.
4/20 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace
DATE OF BURIAL: April 21 1914

20. UNDERTAKER: Wards Undertaking Co.
ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 755
Registered No. 31

1. PLACE OF DEATH.
County of Shoshone
City of Wallace Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Karhu

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: 29 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Logger
(b) General nature of industry, business, or establishment in which employed (or employer): [redacted]
9. BIRTHPLACE (State or Country): Finland
10. NAME OF FATHER: Karhu Salem
11. BIRTHPLACE OF FATHER (State or Country): Finland
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. C. Mowery
(Address) Wallace Ida
15.
Filed 4/20 1914 H. Leo Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Apr (Month) ..... 19 (Day) ..... 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1914 to Apr 19 1914, that I last saw h[illegible] alive on Apr 19 1914 and that death occured on the date stated above, at 10:30 P.M.
The CAUSE OF DEATH* was as follows: Post traumatic abscess of the brain with Meningitis associated
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) [redacted] chronic
(Duration ..... yrs. ..... mos. 2-7 ds.
(Signed) H. C. Mowery M. D.
4/20 1914 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: 4/21 1914
20. UNDERTAKER: Wards Undertaking Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 011
File No. 755
Registered No. 32

1. PLACE OF DEATH.
County of
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Kiebar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. — (Month) (Day) 1 (Year)
7. AGE: 63 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Saloon man
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. C. Howard
(Address) Wallace Ida
15. Filed Apr 23 1914 F. Leo Tenney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 22 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 1913, to Apr 22 1914, that I last saw h~~im~~ alive on Apr 22 1914, and that death occured on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Duration) Yrs. 7 mos. ds.
Contributory (Secondary) Arteriosclerosis
(Duration) several yrs. mos. ds.
(Signed) M. D.
4/23 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace April — DATE OF BURIAL: 24 1914
20. UNDERTAKER: Wards Undertaking Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 104
File No. 7550
Registered No. 33

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. Providence Hosp St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Burns
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 60 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph L. Frohelay
(Address) Wallace Idaho

15. Filed Apr 30 1914 H. Leo Quigley Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 25 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1914, to April 25 1914, that I last saw him alive on April 25 1914, and that death occured on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary): Acute Alcoholism
(Duration) 20 Yrs. mos. 10 ds.

(Signed) D. Mowatt M. D.
April 29 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Peabody, Mass. DATE OF BURIAL: April 27 1914

20. UNDERTAKER: Bruce & Wastell ADDRESS: Wallace Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 756

Registered No. 19

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. 3704 East Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos. S. King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Jan. (Month) 22 (Day) 1879 (Year)

7. AGE: 35 yrs. 2 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kansas,

10. NAME OF FATHER: R. L. Knight

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: E. Thornton

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John L. Knight
(Address) Lewiston

15.
Filed 5-10- 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1913, to April 9 1914, that I last saw her alive on April 5 1914, and that death occurred on the date stated above, at 6-15 M.

The CAUSE OF DEATH* was as follows:

Exhaustion

Potts Disease

(Duration) 2 yrs. 11 mos. ds.

Contributory (Secondary) Potts disease

(Duration) 3 yrs. 11 mos. ds.

(Signed) O. E. Carson M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Lewiston | DATE OF BURIAL: Apr 10 1914

20. UNDERTAKER: O. E. Carson | ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 756

Registration District No. 96
Primary Registration District No. 1009
Registered No. 96

1. PLACE OF DEATH.
County of Nezperce
City of Lewiston (No. ....., Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1897 (Year)

7. AGE: 16 yrs. 6 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: C. Shore

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Alice Gesgby

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Butler
(Address)

15. Filed 5-10- 1914 L Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1914, to apr 16 1914, that I last saw h.er alive on Apr 16 1914, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis & Pregnancy
(Duration) ..... yrs. ..... mos. 1/4 ds.
Contributory (Secondary) Shock
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer G Bradeen M. D.
Apr 17 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs ....mos 4 days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death?
Former or usual residence Lapwai Ida

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Lewiston	Apr 18 191...

20. UNDERTAKER	ADDRESS
J. Bassar	Lewiston

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 7569
Registered No. 91

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Norberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Widowed

6. DATE OF BIRTH: Jan. (Month) 31 (Day) 1849 (Year)

7. AGE: 65 yrs. 2 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Peter Norberg

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil E. Norberg
(Address) Lewiston Ida.

15. Filed 5-10-1914 L. J. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby. 15 1914, to April 18 1914, that I last saw him alive on April 18 1914, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 66 4 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Fred L. Evans M. D.
Apr. 22 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Apr 23 1914

20. UNDERTAKER: L. Bassar — ADDRESS: Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston (No. 0122, 7 st St.)

File No. 751

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie E. Hadley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widowed

6. DATE OF BIRTH

Dec. (Month) 29 (Day) 1860 (Year)

7. AGE

53 yrs. 3 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ontario Canada

10. NAME OF FATHER Robt Matthews

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm A Hadley

(Address) Lewiston Ida.

15.

Filed Oct 10 1914 L Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 17 1914, to Apr 26 1914, that I last saw her alive on Apr 24 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Bright Disease

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Perkins M. D.

19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Town Site — DATE OF BURIAL: Apr 27 1914

20. UNDERTAKER: C. Lassar — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

File No. 7561
Registered No. 4
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ruby Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1 (Month) 22 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malad

10. NAME OF FATHER: Ruban M Williams

11. BIRTHPLACE OF FATHER (State or Country): Malad Ida

12. MAIDEN NAME OF MOTHER: Marier Tibbatts

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruban M Williams
(Address) Malad Ida

15. Filed 7/6 1914 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Probably Heart failure died not seen Phed until after death.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J F Allen M. D.
7/6 1914 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho
DATE OF BURIAL: Feby 8 1914

20. UNDERTAKER: D C Johnson
ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 756

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

1. PLACE OF DEATH.
County of Oneida
City of Malad
Registration District No. 11
Primary Registration District No. 3769
(No. ....., ... St.)

2. FULL NAME Mabel Olive Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 15 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: ...0...
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malad

10. NAME OF FATHER: Alvah Smith

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Inga Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alvah Smith
(Address) Malad

15. Filed 9/18 191 4 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1914, to July 17 1914
that I last saw h[illegible] alive on July 16 1914,
and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Allen M. D.
July 18 1914 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho
DATE OF BURIAL: July 19th 1914

20. UNDERTAKER: A E Johnson
ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 756
Registered No. 6

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2669
City of Samaria (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Beatrice Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH 2 (Month) 1 (Day) ..... (Year)

7. AGE ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Samaria

10. NAME OF FATHER Christensen

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Cathryn Williams

13. BIRTHPLACE OF MOTHER (State or Country) Samaria Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Kerns
(Address) Malad Ida

15. Filed 2/23 1914 W. C. Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2 (Month) – 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10 1914 to Jan dth 191.. that I last saw her alive on 2/10 1914 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows: Tuberculosis (Acute)

..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory Causes
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M. D.
2/25 1914 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Samaria Cem. | DATE OF BURIAL ..... 191..

20. UNDERTAKER D. E. Johnson | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7566

Name Beatrice Williams

Date of Death Feb. 21 1914

Cause of Death Acute Bronchitis

Contributary Cause of death

(Sign here) J. F. McKinnon M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2184-0
(No. ..... St.)

File No. 751
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Oakden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
April (Month) 10 (Day) 1847 (Year)

7. AGE
71 yrs. 11 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Oakden

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Philip Oakden
(Address) Idaho Falls Idaho

15.
Filed Apr 11 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1914, to April 9 1914
that I last saw him alive on April 9 1914
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Ia
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Fuller M. D.
4/11 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Merrian, Idaho | DATE OF BURIAL: 4/12 1914

20. UNDERTAKER: C C Dimmoodey | ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2197
(No. Fuller Hospital St.)

File No. 756
Registered No. 36
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hazel A Crowther Valentine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
April 23 1891
(Month) (Day) (Year)

7. AGE
22 yrs. 11 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Salt Lake City

10. NAME OF FATHER Shepherd Crowther

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary A Glenn

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Shepherd Crowther
(Address) Rigby Idaho

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 7 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1914 to Apl 7 1914, that I last saw her alive on ..... 191..., and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Inflammatory Rheumatism
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Anderson M. D.
19... (Address) Rigby

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho — DATE OF BURIAL: 4/10/1914

20. UNDERTAKER: C E Linwood — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7569
Registered No.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. 0, "C" St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank A Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 24 (Day) 1890 (Year)

7. AGE: 24 yrs. 3 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: News Agent
(b) General nature of industry business, or dstablishment in which employed (or employer): at Depot

9. BIRTHPLACE (State or Country): Ogden, Utah

10. NAME OF FATHER: Henry H Butler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Agnes S. Anderson

13. BIRTHPLACE OF MOTHER (State or Country): London, Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) * Henry H Butler by Dinwoody
(Address) Ogden, Ut.

15. Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1914, to Apr. 7 1914, that I last saw him alive on Apr. 7 1914, and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) ... yrs. 1 mos. ... ds.
Contributory (Secondary): Todic Neuritis
(Duration) ... yrs. ... mos. 24 ds.

(Signed) A. P. Sedgwick M. D.
4/8 1914 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden, Utt. | DATE OF BURIAL: 4/9 1914

20. UNDERTAKER: C.E. Dinwoody | ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTFS. & BDRS. 19760

* Mr. Butler quarantined

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7 3
Primary Registration District No.
(No. ....., ... St.)

File No. 757
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Henry Bortel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Aug (Month) 4 (Day) 1835 (Year)

7. AGE: 78 yrs. 6 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: — Bortel

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Miller

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Bortel
(Address) Home

15. Filed Apr 9 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 30 1914, to Apr 7 1914, that I last saw h[illegible] alive on Apr 7 1914 and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.
Contributory (Secondary) Chronic Nephritis
(Duration) yrs. 6 mos. ds.

(Signed) [signature] M. D.
Apr 9 1914 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: Apr 9 1914

20. UNDERTAKER: Dunwoody Fun. Co — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)

File No. 7521
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virginia Elaine Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1912 (Year)

7. AGE: 2 yrs. 1 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Simpson Jensen

11. BIRTHPLACE OF FATHER (State or Country): Provo Utah

12. MAIDEN NAME OF MOTHER: Esther Coffin

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Simpson Jensen
(Address) Shelley R.F.D. No. 2.

15. Filed April 5 1914 W. E. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Immediate death 191..., to ..... 191...,
~~that I last saw him alive~~ on ..... 191...,
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Drowned in irrigation canal - accidental.

.....(Duration).....yrs.....mos.....ds.

Contributory (Secondary) .....
.....(Duration).....yrs.....mos.....ds.

(Signed) W. E. Parker M. D.
4-5 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rye Cemetery South Idaho | DATE OF BURIAL: April 1914

20. UNDERTAKER: Simpson Jensen | ADDRESS: Blackfoot Shelley R.F.D. No 2

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Tabor (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2192

File No. 1514
Registered No. 20
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: April (Month) 15th (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many 31 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tabor Idaho.

10. NAME OF FATHER Eugene F. Allen.

11. BIRTHPLACE OF FATHER (State or Country) Webster City Iowa

12. MAIDEN NAME OF MOTHER Etta May Baldwin.

13. BIRTHPLACE OF MOTHER (State or Country) Tiffin Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Allen
(Address) Tabor Ida.

15. Filed April 13 1914 M E Pettis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ 1914, to April 13 1914
that I last saw him alive on April 3 1914
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Premature Delivery
(M. C. Pettis, Reg'd)
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John B. Cooper M. D.
April 14 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marland Cemetery | DATE OF BURIAL: April 14 1914

20. UNDERTAKER: E. F. Allen. ADDRESS: Tabor Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Insane Asylum St.)

File No. 757
Registered No. 21
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth N. F. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	white	married

6. DATE OF BIRTH
July (Month) 16 (Day) 1863 (Year)

7. AGE
51 yrs. 8 mos. 23 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER Arthur King

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Eliza Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Smith
(Address) Pocatello

15. Filed April 13th 1914 W. E. Pierce Local Registrar
Idaho

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1913, to April 12th 1914, that I last saw her alive on April 12 1914, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) ..... yrs. ..... mos. Few hours ds.

Contributory (Secondary) Senile Dementia

(Duration) Don't Know yrs. ..... mos. ..... ds.

(Signed) Leo Snyder M. D.

April 14 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 10 yrs. ..... mos. 13 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL St Anthony Idaho. DATE OF BURIAL ..... 191...

20. UNDERTAKER E J Peck ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 251
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roswell King Lutz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	M

6. DATE OF BIRTH
Aug (Month) 2nd (Day) 1911 (Year)

7. AGE
2 yrs. 8 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bingham Co Ida

10. NAME OF FATHER George Albert Lutz

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mercy Whiting

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Lutz
(Address) Blackfoot Idaho

15.
Filed April 23 1914 M. E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 22nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1914, to April 22 1914, that I last saw him alive on April 12 1914, and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 21 ds.
Contributory (Secondary) Enlarged Tonsils Adenoids

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. E. Patrie M. D.
4/23 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida
DATE OF BURIAL: April 24 1914

20. UNDERTAKER: Geo A Lutz
ADDRESS: Blackfoot Bonnie Co

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2 19e

(No. Thomas Pierce St.)

File No. 754

Registered No. 23

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud Louise Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1869 (Year)

7. AGE: 44 yrs. 8 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Jacob Hutzley

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John R Williams
(Address) Blackfoot R F D No 2

15. Filed April 25 1914. M. E. Tabor Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1914, to April 22 1914, that I last saw her alive on April 22 1914, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Cardiac Stenosis

(Duration) — yrs. — mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. W Metcalf M. D.

4/27 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Thomas Cem | DATE OF BURIAL: April 24 1914

20. UNDERTAKER: E J Peck | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7576

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 127

Primary Registration District No. 1007

County of Bonneville

City of Blackfoot. (No. North Shelling ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Bice

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 3 1838
Abt Known
(Month) (Day) (Year)

7. AGE: 75 Yrs. 11 Mos. 23 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Unknown

10. NAME OF FATHER
unknown

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER
"

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. T. Peck
(Address) Blackfoot

15. Filed April 26 1914 M. E. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 26 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1914, to April 26 1914, that I last saw h~~as~~ alive on April 26 1914, and that death occured on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.

4/27 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodruff Ind. — DATE OF BURIAL: 4/28 1914

20. UNDERTAKER: E. T. Peck. Blackfoot Idaho — ADDRESS

BYRNE - YORK CO., PTRS. & BKBS. 24058

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 751

Registered No. 14

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 121

County of Bingham Primary Registration District No. 2194

City of Blackfoot (No. ....., ... St.)

R F D No 4.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Jordan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	W	Married

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1843 (Year)

7. AGE: 70 yrs. 2 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Jordan

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anna Jordan

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Davis M.D.
(Address) Blackfoot Ida

15. Filed Mch 10 1914 W. E. Pulsipher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1914, to Mar 10 1914 that I last saw him alive on Mar 10 1914 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

..... (Duration) 15 yrs. — mos. — ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Davis M. D.

3/10 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Ida — DATE OF BURIAL: Mch 11 1914

20. UNDERTAKER: C. Thompson — ADDRESS: Moreland

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Avenue corner Main St.)

File No. 7578
Registered No. 15
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Otto Glaugman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 26 (Day) 1878 (Year)

7. AGE: 35 yrs. 9 mos. 23 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Dayton, Iowa

10. NAME OF FATHER: Benedict Glaugman

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Emma Cramer

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry L Glaugman
(Address) Idaho Falls,

15. Filed Mch 19 1914 M E Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10th 1913, to Mch 19 1914, that I last saw him alive on Mch 18 1914, and that death occurred on the date stated above, at 1-00 A.M.

The CAUSE OF DEATH* was as follows:

Progressive Paralysis

(Duration) Don't Know yrs. mos. ds.

Contributory (Secondary) Dementia Praecox

(Duration) Don't Know yrs. mos. ds.

(Signed) Geo F Hyde M. D.

Mch 19 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida | DATE OF BURIAL ....191...

20. UNDERTAKER: C. E. Linwood Lacy | ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 151

Registered No. 16

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. 361 W Judicial St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. (Month) Dec (Day) 30 (Year) 1843

7. AGE: 71 Yrs. 2 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER James Brendenhall

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Eliza Hoops

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucas Stewart

(Address) Springville Utah

15. Filed Mch 22 1914

M. E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1914, to March 21 1914, that I last saw her alive on March 7 1914, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

.....(Duration) ——— Yrs. 1 mos. 15 ds.

Contributory (Secondary) Cardiac insufficiency

.....(Duration 2 yrs. — mos. — ds.

(Signed) C.W. Beck M. D.

3/21/1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ——yrs. 3 mos. ——days. In the State. 8 yrs. 3 mos. ——days

Where was disease contracted if not at place of death? Springville Utah.

Former or usual residence Springville, Utah

19. PLACE OF BURIAL OR REMOVAL: Springville Utah — DATE OF BURIAL ..... 191...

20. UNDERTAKER: E F Peck — ADDRESS Blackfoot

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7579

Name Caroline Stewart

Date of Death Mar. 21. 1914

Cause of Death Acute Bronchitis

Contributary Cause of death Myocarditis

(Sign here) W. W. Peck M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 219

City of Blackfoot (No. Idaho Moore Addition St.)

File No. 75

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Cook

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: December (Month) 18th (Day) 1875 (Year)

7. AGE: 38 yrs. 3 mos. 6 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lovelock Nev.

10. NAME OF FATHER: Chas. Albertson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Hepworth

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas N. Albertson

(Address) Albion Ida

15. Filed Mch 25 1914 M. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH. March 24 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18th 1914, to March 24 1914, that I last saw her alive on March 24 1914, and that death occurred on the date stated above, at 10-45 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Peritonitis

Don't Know (Duration) yrs. mos. ds.

Contributory (Secondary) Acute Mania

Don't Know (Duration) yrs. mos. ds.

(Signed) Geo T Bell M. D.

March 25 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs 6 mos. 6 days. In the State Don't Know yrs. mos. days.

Where was disease contracted if not at place of death? Don't Know

Former or usual residence Albion Idaho

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho

DATE OF BURIAL: 191...

20. UNDERTAKER: E J Ruck

ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 7581
Registered No. 18

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Blackfoot Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Treff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 11 (Day) 1 (Year)

7. AGE 28 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Philip Mohr

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Katie Rhanenstuel

13. BIRTHPLACE OF MOTHER (State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Treff
(Address) .....

15. Filed Mch 27 1914 — M E Patrick, Local Registrar

SYMS - YORK CO., PTRS. & BURS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 8 1914, to Mch 26 1914, that I last saw he alive on Mch 26 1914, and that death occured on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:
Puerpal Fever
(Duration) Yrs. mos. 13 ds.
Contributory (Secondary) Child Birth
(Duration yrs. mos. 18 ds.

(Signed) H. J. Simmons M. D.
3/26 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 8 days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Idaho Idaho

19. PLACE OF BURIAL OR REMOVAL: Walla Walla Washington — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: E F Peck — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 758
Registered No. 12

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Mary Hawley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 25 (Day) 1866 (Year)

7. AGE: 47 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home maker
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Wm. Parks

11. BIRTHPLACE OF FATHER (State or Country): London Eng.

12. MAIDEN NAME OF MOTHER: Elizabeth Rice

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William L Hawley
(Address) Blackfoot

15. Filed Feb. 20 1914
M. E. Price
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13 1914, to Feb. 18 1914, that I last saw her alive on Feb. 18 1914, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) F. W. Watson M. D.
2/18 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Idaho
DATE OF BURIAL: Feb 191

20. UNDERTAKER: E J Peck
ADDRESS: Blackfoot

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 758

Registered No. 13

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles E. Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucassian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 24 (Day) 1877 (Year)

7. AGE: 36 Yrs. 8 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Thresher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mason Co Ill

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. E. Boyle

(Address) Blackfoot

15. Filed Feb 28 1914

M. E. Petrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1914, to Feby 27 1914, that I last saw h... alive on Feby 27 1914, and that death occured on the date stated above, at 11-40 P M.

The CAUSE OF DEATH* was as follows:

Progressive Bulbar Paralysis

(Duration) Don't Know yrs. mos. ds.

Contributory (Secondary) Don't Know

(Duration Don't Know yrs. mos. ds.

(Signed) Geo. Boyle M. D.

Mch 2 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 5 days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? Don't Know

Former or usual residence Twin Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho

DATE OF BURIAL ... 191...

20. UNDERTAKER: E J Puck

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 756

Registered No. 40

1. PLACE OF DEATH. Registration District No. 29

County of Kootenai Primary Registration District No. 1050

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Child of Clarence Eggars

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: March 3 1914
(Month) (Day) (Year)

7. AGE: ... yrs. 3 mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Clarence Eggars

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 3-4- 1914 M. A. Copeland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 3 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1914, to ..... 191....
that I last saw h[im] alive on Feb 15 1914
and that death occurred on the date stated above, at 3 A. M.
The CAUSE OF DEATH* was as follows:

Congenital Heart Lesion

..... (Duration) ... yrs. 3 mos. ... ds.

Contributory (Secondary) .....
..... (Duration) ... yrs. ... mos. ... ds.

(Signed) J. O. Wiggins M. D.
March 4 1914 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29.

Primary Registration District No. 1050

File No. One. 585

Registered No. 39.

County of Kootenai

City of C d A

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Elizabeth Bowers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	

6. DATE OF BIRTH

..... (Month) ..... (Day) 1823 (Year)

7. AGE

91 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER John Gray

11. BIRTHPLACE OF FATHER (State or Country) Pen

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Norton

(Address) 16" & Pine W

15.

Filed 3-4 1914 M. McDonald Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1914, to March 1st 1914, that I last saw her alive on Feb 28 1914, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Dysentery

..... (Duration) ..... yrs. 1 mos. ..... ds.

Contributory .....

(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Burbey M. D.

March 1914 (Address) Coeur D'alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	March 1914

20. UNDERTAKER	ADDRESS
D Lowe	CdA

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

File No. 75-1

County of Kootenai

City of Coeur d Alene (No. ....., ... St.)

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jas. G. Finney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH

..... (Month) 1 (Day) ..... (Year)

7. AGE

..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER J B Finney

11. BIRTHPLACE OF FATHER (State or Country) Miss

12. MAIDEN NAME OF MOTHER Susie Eswodell

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Brother

(Address) 924 Front

15. Filed 9-20 1914 M C Dolard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March (Month) 2nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1913, to March 1914, that I last saw him alive on March 2 1914 and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) General oedema

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Jno Bunby M. D.

19 .... (Address) Coeur D'Alene Ida,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	March 3 1914

20. UNDERTAKER	ADDRESS
J J Sun	C d A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 75

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonner

City of Copeland

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Mrs. Dan. Chisholm.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Jan. (Month) 31 (Day) 1878 (Year)

7. AGE: 36 yrs. ..... mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: J. M. Lucas

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Barbara Erbenwein

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruth Chisholm
(Address) Copeland, Idaho.

15. Filed April 20th 1914. E. E. Fry. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 3rd. (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h er alive on Jan. 21st. 1914.
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pernicious anaemia

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry, M. D.
4/20 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Copeland Ida	Feb 3rd 1914
20. ~~UNDERTAKER~~ E. D. Hodgson	ADDRESS Spokane Wn

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 2186.

File No. 7585

County of Bonner

City of Bonners Ferry Ida. (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Dinwoit Waterman

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 16th (Day) 1842 (Year)

7. AGE: 71 yrs. 10 mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Waterman

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Lamb

13. BIRTHPLACE OF MOTHER (State or Country): Wales England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John L. Waterman
(Address) Bonners Ferry Ida

15.
Filed Mar. 17 1914. E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Gunshot wounds of chest.
(Homicidal)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

3/17 1914. (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 3/18 1914

20. UNDERTAKER: John J. Moore — ADDRESS: Bonners Ferry Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Bonners

Primary Registration District No. 246

File No. 7589

City of Bonners Ferry (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Luther Frank Duvall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: June (Month) 23 (Day) 1879 (Year)

7. AGE: 34 yrs. 6 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Fruit farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Denver Colo

10. NAME OF FATHER John R. Duvall

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Lilly A Duvall

13. BIRTHPLACE OF MOTHER (State or Country) Denver Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W S & Duvall
(Address) Bonners Ferry Idaho

15. Filed Mar. 14 th 1914 E E Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13 th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1914 191 , to Mar 13, 1914 191 , that I last saw him alive on Mar 12, 1914 191 , and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the lungs.

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) Bronchial pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) Leslie J. Stauffer M. D.

April 6 1914 (Address) Bonners Ferry Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver Colo | DATE OF BURIAL: 3/15 1914

20. UNDERTAKER: John T. Moore | ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 37 W Harrison St.)
File No. 3751
Registered No. 142
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Delbert M. Tubbs
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 20 (Day) 1913 (Year)

7. AGE: yrs. 8 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: Alex Tubbs

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Marian Wheelock

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex Tubbs
(Address) 37 W Harrison Pocatello Ida

15. Filed 3/3 1914 O B Avery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 2 1914, to Mch 3 1914, that I last saw h alive on Mch 3 1914, and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. Smith Downey M. D.

Mch 3 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Howe Cemetery DATE OF BURIAL Mch 5 1914

20. UNDERTAKER W. H. Walker ADDRESS Pocatello Ida

HYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2760
(No. 760 N. 2nd St.)

File No. 3750
Registered No. 143
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs Rachel Dwyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: March (Month) 10 (Day) 1885 (Year)

7. AGE: 28 yrs. 11 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Wm Dover.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Rachel Dover

13. BIRTHPLACE OF MOTHER (State or Country): Pocatello

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Dover.
(Address) Pocatello Ida

15.
Filed 3-6 1914 O B Seely
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.., to Mch 5 1914, that I last saw her alive on Mch 5 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as ~~follows~~:
Pelvic abscess to general peritonitis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Infection of tubes
..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) O B Seely M. D.
3-5-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Old Cemetery — DATE OF BURIAL: Mch 8 1914

20. UNDERTAKER: W. L. Nasser — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 759

Registered No. 144

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 216
(No. 21, Jack St.)

2. FULL NAME John Griffith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1 (Month) (Day) 1861 (Year)

7. AGE: 53 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Dan Griffith

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Catherine James

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Geo A. Whetstone
(Address): Salmon Ida

15. Filed March 10 1914 — March 10 - 1914 — O. J. Beaty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191..., to ... 191...
that I last saw h... alive on ... 191...,
and that death occurred on the date stated above, at 9:45 a M.

The CAUSE OF DEATH* was as follows:

R. R. Accident

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) O. J. Beaty Coroner M. D.
3-10- 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Deerham City Cemetery — DATE OF BURIAL: 3/11 1914

20. UNDERTAKER: W. W. Master — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 3750
Registered No. 145

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. Gen Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry C. Jordan
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept 26th 1880 (Month) (Day) (Year)

7. AGE: 33 yrs. 5 mos. 6 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry business, or dstablishment in which employed (or employer): Furniture

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: John Jordan

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. Jeffreys
(Address) Dearborn Hotel

15. Filed Mch 29, 1914 O. J. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 28 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1914, to March 28 1914, that I last saw him alive on March 28 1914 and that death occurred on the date stated above, at 430 M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr A.M. Newton M. D.
19 ..... (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: B Mountain View
DATE OF BURIAL: March 31 1914

20. UNDERTAKER: Crawford and Schumacher
ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7593

Name Harry C. Jordan

Date of Death March 28. 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death Myocarditis.

(Sign here) A M Newton M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7594

Registered No. 146

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 21 04
(No. County Hospital St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Curly Roach.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): Information Obtainable

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Walker
(Address) Pocatello Ida

15. Filed 4/1 1914 O B Ling Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1913, to Mch 30 1914, that I last saw h[illegible] alive on Mch 30 1914, and that death occurred on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:
Congestion of Lungs
(Duration) 7 yrs. — mos. 9 ds.
Contributory (Secondary) Bright Disease
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A M Newton M. D.
Mch 30 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 27 yrs. — mos. ..... ds. In the State 27 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Pocatello Ida

19. PLACE OF BURIAL OR REMOVAL: Mt View — DATE OF BURIAL: April 1 1914

20. UNDERTAKER: W. W. Walker — ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 759

1. PLACE OF DEATH.
County of Latah
City of Deary P.#1
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Dillman
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed.

6. DATE OF BIRTH: Apr. 21. 1893
(Month) (Day) (Year)

7. AGE: 19 yrs. 11 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Kitchen work
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Ben Webber.

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Annie McCoy.

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): William McCoy
(Address): Deary Id #1

15. Filed 4/13 1914 W. P. Faust. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 13 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 1:45 M.

The CAUSE OF DEATH* was as follows:
shotgun wound—
suicidal.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Faust M. D.
4/13 1914 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wild Rose Cemetery | DATE OF BURIAL: 4/14 1914

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Avon R#1 (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
File No. 754
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion Wood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Dec. (Month) 7 (Day) 1848 (Year)

7. AGE: 65 yrs. 4 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James Wood

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Nancy Aber

13. BIRTHPLACE OF MOTHER (State or Country): Ohio (?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mary Wood
(Address): Avon R. #1

15. Filed 4/17 191 4 P. W. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 16 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 2.05 P.M.

The CAUSE OF DEATH* was as follows:
heart failure reported
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. W. Evans M. D.
3/17 19 14 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Avon Cemetery | DATE OF BURIAL: Apr. 18 191 4.
20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Deary
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ... St.)

File No. 1759
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Dec. 9 1843 (Month) (Day) (Year)

7. AGE: 71 yrs. 4 mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: don't know

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: don't know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur O. Burke
(Address) Deary

15. Filed 4/20 1914 P. V. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 19 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 11. 1914, to Apr. 19. 1914, that I last saw h. alive on Apr 19. 1914, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Primary lateral sclerosis of Spinal Cord.
(Duration) ✓ yrs. ✓ mos. 10 ds.
Contributory (Secondary) cold
(Duration) ✓ yrs. ✓ mos. 10 ds.

(Signed) P. V. Faust M. D.
4/20 1914 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Zion Cemetery | DATE OF BURIAL: 4/21 1914

20. UNDERTAKER: J. E. Pickard | ADDRESS: Deary

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 750
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Deadora Van Hook

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH Sept 7 - 86 1
(Month) (Day) (Year)

7. AGE 27 yrs. 6 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Milon Van Horn

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Mary Brady

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H B Van Hook
(Address) Grangeville Ida

15. Filed April 30 1914 G S Stricklin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 8 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1914, to April 2 1914
that I last saw her alive on April 2 1914
and that death occurred on the date stated above, at 9:40 a. M.

The CAUSE OF DEATH* was as follows:
Puerperal Septicemia

..... (Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stricklin M. D.
April 8 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Prairie View
DATE OF BURIAL April 9 1914

20. UNDERTAKER W E Graham
ADDRESS Grangeville

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Green Creek

Registration District No. 10
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 750
Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Ahlers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE: 49 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Effingham

10. NAME OF FATHER: Jos ahlers

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Mary ahlers

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Father J M Barlocher
(Address) Green Creek Idaho

15.
Filed April 30 1914
G B Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 20 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Sudden death,
no attending Physician

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Father Barlocher M. D.
Jan 22 1914 (Address) Green Creek

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green Creek
DATE OF BURIAL: Jan 22 1914

20. UNDERTAKER: none
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of ..... (No. ....., ... St.)

Registration District No. 10 3
Primary Registration District No. 2181

File No. 7611
Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Clementine Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Aug (Month) 25 (Day) 1904 (Year)
7. AGE: 9 yrs. 10 mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho Co
10. NAME OF FATHER: Harrison Johnson
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Mary Reynolds
13. BIRTHPLACE OF MOTHER (State or Country): Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harrison Johnson
(Address) Grangeville Ida
15.
Filed Apr 30 1914 — G B Stockton, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 14 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 13 1914, to April 14 1914
that I last saw her alive on April 14 1914
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
appendicitis followed by abscess & gangrene
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C W Shuaer M. D.
April 15 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver — DATE OF BURIAL: April 16 1914
20. UNDERTAKER: W E Graham — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-15-12

1. PLACE OF DEATH.

County of Idaho — Primary Registration District No. 1001 — File No. 7601

City of Grangeville (No. ....., ... St.) — Registered No. 2

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Montemore H Wilkins

If death occured in institution or camp instead of street

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Mar 29th (Month) 1914 (Day) (Year)

7. AGE: X yrs. X mos. 12 ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho - Idaho

10. NAME OF FATHER Geo. H. Wilkins

11. BIRTHPLACE OF FATHER (State or Country) Crawford Co. Kas.

12. MAIDEN NAME OF MOTHER Lila J. Rapp.

13. BIRTHPLACE OF MOTHER (State or Country) Mitchell Co. Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo H Wilkins
(Address) Grangeville Idaho

15. Filed Apr 11th 1914 — C W Shuman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-29 1914, to 4-10- 1914 that I last saw him alive on 4-9- 1914 and that death occurred on the date stated above, at 10 9 M.

The CAUSE OF DEATH* was as follows:
Catarrhal obstruction of the gall duct
(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Warner M. D.
4-11-1914 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grangeville — DATE OF BURIAL: Apr 11 1914

20. UNDERTAKER: O. E. Graham — ADDRESS: Grangeville

WRITE PLAINLY. Every item of information must be given. Physicians and Undertakers must write their names PLAINLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9010
Primary Registration District No.
File No. 7602
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Vest Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Apr (Month) 2 (Day) 1840 (Year)

7. AGE: 74 yrs. — mos. 4 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: James Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Elizabeth Vest

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. C. Wheeler
(Address) Emmett Idaho

15. Filed [illegible] 6 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 1914, to Apr 6 1914, that I last saw him alive on Apr 5 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
Heart Disease (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. O. Clark M. D.
Apr 24 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery — DATE OF BURIAL: Apr 7 1914

20. UNDERTAKER: C. D. Buckner — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2011
Primary Registration District No. .....

File No. 7603
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ralph C. Streeter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May 30 1847 (Month) (Day) (Year)

7. AGE: 66 yrs. 10 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Charles Streeter

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Harriet Vanderpel

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Robt Miles
(Address) Emmett Idaho

15.
Filed Apr 28 1914
C. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1914, to April 1914 that I last saw h~~im~~ alive ~~on~~ about March 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Progressive Muscular atrophy

Not known (Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B O'Clark M. D.
April 24 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: Apr 8 1914

20. UNDERTAKER: C D Buckmum
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7601

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
(No. ....., ... St.)

Registration District No. 2010
Primary Registration District No. 1010

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie C. Beers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Dec 22 1840
(Month) (Day) (Year)

7. AGE: 73 yrs. 4 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Henry Heath

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Sarah Bird

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Monte Beers
(Address) Emmett Idaho

15.
Filed 4-28 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 9 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to April 9 1914
that I last saw her alive on April 9 1914,
and that death occurred on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
not Known
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. D. Clark M. D.
April 24 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: Apr 12 1914

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No. 2124
File No. 760
Registered No. 4

1. PLACE OF DEATH.
County of Lewis
City of Nezperce (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Wilson Workman
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 2 (Month) 15 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nezperce Idaho

10. NAME OF FATHER: Chas Workman

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Rose Branch

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Workman
(Address) Nezperce

15. Filed May 6 1914 — J M Jones, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1914 to Apr 24 1914 that I last saw h[illegible] alive on [illegible] 191[illegible] and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Ecrisipelas
.....
.....
(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) J M Jones M. D.
4 24 1914 (Address) Nezperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce — DATE OF BURIAL: 4 26 1914

20. UNDERTAKER: P E Miller — ADDRESS: Nezperce

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

47

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7601
Registered No. 3

1. PLACE OF DEATH.
County of Lewis
City of Nezperce

Registration District No.
Primary Registration District No. 2124
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas R Hancock

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widowed

6. DATE OF BIRTH: June (Month) 19 (Day) 1869 (Year)

7. AGE: 44 yrs. 8 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section (R R) foreman
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ark.

10. NAME OF FATHER: E. M. Hancock

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Elizabeth Hancock

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. A. Jeffreys
(Address) Nezperce

15. Filed 6-6-1914 W. H. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18 1914, to Mar 20 1914 that I last saw him alive on Mar 20 1914 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Uraemia

36 hrs.
(Duration) yrs. mos. ds.

Contributory (Secondary) Chronic Interstitial Nephritis
(Duration) Several years yrs. mos. ds.

(Signed) O. A. Jeffreys M. D.
4-6 1914 (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce — DATE OF BURIAL: 3-21 1914

20. UNDERTAKER: P. E. Miller — ADDRESS: Nezperce

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Basin
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 130
Primary Registration District No. 2199
(No. ....., ... St.)

File No. 11 7607
Registered No. 7
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tressie Anetta Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July 22 1910 (Month) (Day) (Year)

7. AGE: 4 yrs. 7 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Abram Arnold Baker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lena Anetta Polson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) E. H. Baker, Basin

15. Filed 5/1 1914 E P Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 22 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 19. 1914, to Apr. 22 1914, that I last saw h-r alive on Apr. 20 1914 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Bronchs-Pneumonia
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Measles
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) E P Oldham M. D.
4/23 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basin - Idaho
DATE OF BURIAL: 4-24 1914

20. UNDERTAKER: A. Sagers
ADDRESS: Basin

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Marion
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 170
Primary Registration District No. 2199
(No. ....., ... St.)

File No. II 760
Registered No. 8

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alva Deoul Johanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: June 11 1913 (Month) (Day) (Year)
7. AGE: ..... yrs. 10 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Alva R. Johanson
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Evelyn Hokanson
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alva R. Johanson
(Address) Marion
15. Filed 5/9 1914 E. P. Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 22 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 18. 1914, to Apr 19 1914, that I last saw h[illegible] alive on Apr 19 1914, and that death occurred on the date stated above, at 11 4p M.
The CAUSE OF DEATH* was as follows:
Meningitis
Secondary
(Duration) — yrs. — mos. 10 ds.
Contributory Otitis Media
(Secondary)
(Duration) — yrs. — mos. 30 ds.
(Signed) E P Oldham M. D.
4/23 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marion
DATE OF BURIAL: 4/24 1914
20. UNDERTAKER: H W Isaacsons
ADDRESS: Marion Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7608

Name Alva Deverl Johanson

Date of Death Apr. 22, 1914.

Cause of Death Secondary Meningitis

Contributary Cause of death Influenzal Otitis Media

(Sign here) E P Olohan M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 7606
Registered No. 24

1. PLACE OF DEATH.
County of Latah
City of Boviel
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm L. Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Dec. (Month) 19th (Day) 1890 (Year)

7. AGE
24 Yrs. 4 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Mich

10. NAME OF FATHER: Chas. Green

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER: Ella Toppings

13. BIRTHPLACE OF MOTHER
(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Chas. Green
(Address) Boviel Ida

15.
Filed Apr 19 1914
D F Rae
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 9:20 P.M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) about 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. N. Clark M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boviel Ida — DATE OF BURIAL: Dec 21 1914

20. UNDERTAKER: J. L. Champine — ADDRESS: Boviel Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 701
Registered No. 31

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carol Ricketts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Dec (Month) 27 (Day) 1910 (Year)

7. AGE: 3 yrs. 3 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jesse B Ricketts

11. BIRTHPLACE OF FATHER (State or Country) Wash. - state of

12. MAIDEN NAME OF MOTHER Leola Davis

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Ricketts
(Address) Moscow

15. Filed Apr 15 1914 [signature illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1914, to April 13 1914, that I last saw h.. alive on April 13 1914, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Croupous Pneumonia

(Duration) ..... yrs. ..... mos. 13 ds.
Contributory Olitis Media
(Secondary)
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) F. W. Leitch M. D.
19..... (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Apr 15 1914

20. UNDERTAKER: Geo Gletty — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 761
Registered No. 32

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adeline Johnson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem.	White.	Widow

6. DATE OF BIRTH: Feb. (Month) 20 (Day) 1848 (Year)

7. AGE: 66 yrs. 1 mos. 25 ds. IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: C. Smith

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Adeline Baily

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. F. R. Moore
(Address) Moscow

15. Filed Apr 15 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1914, to Apr 15 1914, that I last saw her alive on Apr. 14 1914, and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Arteriosclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. F. Rae M. D.
Apr 15 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Moscow Ida. DATE OF BURIAL: Apr 15 1914

20. UNDERTAKER: Geo. Stelz ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
(No. ....., ... St.)

File No. 761
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas A. Lawson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Nov. (Month) 16 (Day) 1905 (Year)

7. AGE
8 yrs. 4 mos. 29 ds.
IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Oklahoma

10. NAME OF FATHER John S Lawson

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Blanche Dawson

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Lawson
(Address) Potlatch Idaho

15.
Filed Dec. 17 1914 W. F. Carr
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1914, to April 15 1914, that I last saw him alive on April 15 1914, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Shock

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) accidental injury

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. L. Gutman M. D.

19 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Palouse Wash	Dec 18 1914

20. UNDERTAKER	ADDRESS
E Anderson	Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 761
Registered No. 34

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans A Paulson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1843 (Year)

7. AGE: 68 yrs. 5 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Paul Fredrickson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Paulson
(Address) Palouse

15. Filed Apr 13 1914 J F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1914, to April 13 1914, that I last saw him alive on April 13 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Gangrene

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gutman M. D.

19 .... (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Palouse Wash. DATE OF BURIAL (4) April 14 1913

20. UNDERTAKER: Geo. Seltz & Son ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 761

Registered No. 30

1. PLACE OF DEATH

County of Latah

City of Moscow (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie N. Weeks.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug. (Month) 24 (Day) 1879 (Year)

7. AGE: 34 yrs. 7 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moscow

10. NAME OF FATHER: Hans D. Smith

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Lina Simonson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Smith
(Address) Moscow Ida.

15. Filed Apr 14 1914 D.F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1914, to April 13 1914, that I last saw h[illegible] alive on April 13 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis (Tuberculous)

(Duration) — yrs. — mos. 8 ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) — yrs. — mos. — ds.

(Signed) J. C. Wirk M. D.

April 13 1914 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: Apr 16 1914

20. UNDERTAKER: Geo Kelly

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 761
Registered No. 30

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. 6, St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Woodrow Byers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: May (Month) 9 (Day) 1912 (Year)

7. AGE: 1 yrs. 11 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow

10. NAME OF FATHER Ephraim Byers

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Johnnah Barker

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ephraim Byers
(Address) .....

15. Filed Apr. 24 1914 D. H. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1914, to April 23 1914, that I last saw h~~im~~ alive on April 23 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buel Cem. DATE OF BURIAL: 4-27-1914

20. UNDERTAKER: Geo Stitz ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011

File No. 7616
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. M. Franklin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb 2 (Month) 23 (Day) 1834 (Year)

7. AGE: 80 yrs. 1 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. K. Franklin
(Address) Moscow
April 19th 1914

15.
Filed Apr 19 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 17th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16, 1914, to April 16th 1914, that I last saw h— alive on April 16th 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Senility

(Duration) ..... yrs. 2 mos. ..... ds.
Contributory (Secondary) Probably Tuberculosis
(Duration) About 1 Year yrs. ..... mos. ..... ds.

(Signed) W. A. Adair M. D.
(Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 4/19 1914

20. UNDERTAKER: Lew Hattz
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6!
Primary Registration District No. 1611
File No. 7617
Registered No. 26

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ..... Gotman Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Virginia Stein

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
March 23 1875
(Month) (Day) (Year)

7. AGE
38 yrs. 1 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER George Prettyman

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. L. Gotman
(Address) Moscow, Idaho

15.
Filed May 2 1914 W. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 1 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1914, to May 1 1914, that I last saw h[illegible] alive on May 1 1914, and that death occurred on the date stated above, at 9:10 M.

The CAUSE OF DEATH* was as follows:
Salpingitis - Non-specific

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas L Gotman M. D.
May 2 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Estes Idaho	5/6 1914
20. UNDERTAKER	ADDRESS
[illegible] Slater	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760



Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119 File No. 761
City of Mink Creek (No. ....., ... St.) Registered No. 28
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Eyring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug (Month) 2 (Day) 1840 (Year)

7. AGE: 68 yrs. 8 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers Wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Boo Kalder

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. F. Eyring
(Address) Mink Creek Ida

15.
Filed 3/6 1917 Allen P Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No medical attendant 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Had Rheumatism and seemed to be improving - was sun in the morning and then left alone 10 or 15 minutes when she was found dying -
(Duration) — yrs. 7 mos. ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen P Curtis M. D.
19... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mink Creek — DATE OF BURIAL: 20 1914

20. UNDERTAKER: D J Hansen — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 761
Registered No. 21
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma C Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Apr. (Month) 19 (Day) 1841 (Year)

7. AGE: 73 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home W Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Samuel Clark

11. BIRTHPLACE OF FATHER (State or Country)*: Penn

12. MAIDEN NAME OF MOTHER: Rebecca Evans

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hattie N Thatcher
(Address) Preston Ida

15. Filed May 4 1914 Dr. Allen Rutter Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1914., to Apr. 13 1914
that I last saw her alive on Apr. 12 1914.
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of the breast

(Duration) 3 yrs. 3 mos. 19 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr O F Canfield M. D.
19..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: Apr 17 1914

20. UNDERTAKER: D J Hansen — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ....., ... St.)

File No. 752

Registered No. 20

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Preston R Last

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Apr (Month) 19 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 Weeks

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Roberts Last

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Hargusty

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mattie G. D. Last

(Address) Preston Idaho

15.

Filed 5/14 1914 D. Allen Rees
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10 1914, to April 14 1914, that I last saw him alive on April 12 1914, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Allen Rees M. D.

4/10 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Apr 12 1914

20. UNDERTAKER	ADDRESS
D J Hansen	Preston

4VM8 - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27

Primary Registration District No. 2119

File No. 7621

Registered No. 22

1. PLACE OF DEATH.

County of Bannock

City of Mink Creek (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Karen Margeret Keller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: 7 (Month) 9 (Day) 1821 (Year)

7. AGE: 92 yrs. 8 mos. 26 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Houswife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bornholm Denmark

10. NAME OF FATHER: Peter Valentine

11. BIRTHPLACE OF FATHER (State or Country): Bornholm Denmark

12. MAIDEN NAME OF MOTHER: Margeret Kofoed

13. BIRTHPLACE OF MOTHER (State or Country): Bornholm Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Keller
(Address) Preston Ida

15. Filed May 4 1914 L. Allen Keeler. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No physician in attendance 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen L. Carter M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mink Creek — DATE OF BURIAL: April 7 1914

20. UNDERTAKER: P J Hansen — ADDRESS: Preston Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Mink Creek

Primary Registration District No. 2119

File No. 762

City of " "

(No. ....., ... St.)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maren Jensen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	

6. DATE OF BIRTH: Mar. (Month) 7th, (Day) 1843 (Year)

7. AGE: 71 yrs. 1 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fyn Denmark

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. C. Nelson

(Address) Mink Creek

15.

Filed 3/6 1914 Allen Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1914, to Jan. 21 1914, that I last saw him alive on ..... 191..., and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Senile Decay - Immediate Cause Not Known - went to bed at usual and found dead in the morning.

(Duration) ..... yrs. 4 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen Cutler M. D.

19.... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mink Creek. W. A. Skidmore	Apr. 23 1914
20. UNDERTAKER	ADDRESS
W. A. Skidmore	Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 7623
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Burd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	married

6. DATE OF BIRTH: Jan. 27 (Month) (Day) 1887 (Year)

7. AGE: 27 yrs. 3 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Idaho~~ Virginia

10. NAME OF FATHER: John Burd

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Allie Burd
(Address) Nampa, Idaho

15. Filed April 15th 1914 John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1914, to April 13 1914, that I last saw him alive on April 13 1914 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Pernatal Gastric Ulcer

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Bradley M. D.
April 19 14 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary — DATE OF BURIAL: April 15 1914

20. UNDERTAKER: W C Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 762
Registered No. 20

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Farley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female.
4. COLOR OR RACE: white.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.
6. DATE OF BIRTH: July (Month) 4 (Day) 1864 (Year)
7. AGE: 49 yrs. 9 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: home wife.
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: Frank Wing
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Dont know
13. BIRTHPLACE OF MOTHER (State or Country): New York.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hazel Farley
(Address) Parma Ida.
15.
Filed April 17 1914
Jos. S. Myers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 15 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 1 1914, to April 15 1914
that I last saw her alive on Sept 15 1913
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Infection of Gall Bladder
..... (Duration) ..... yrs. 1 mos. ..... ds.
(Signed) F. P. Arnett D.O. M. D.
April 17 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell — DATE OF BURIAL: April 17 1914
20. UNDERTAKER: Platt Sackett — ADDRESS: Caldwell Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 762
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amanda Louisa Allebaugh

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1838 (Year)

7. AGE: 76 yrs. 2 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Daniel Benden

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Nancie Fisher

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel Allebaugh
(Address) Caldwell

15.
Filed April 20 — 1914
John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1914, to April 18 1914
that I last saw h[illegible] alive on April 18 1914
and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
old age and complicated cardiac [illegible] accompanied by failure of kidney action
(Duration) — yrs. 6 mos. — ds.
Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. R. Meredith M. D.
April 15 1914 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge Cemetery
DATE OF BURIAL: Apr 20 1914

20. UNDERTAKER: Platt Peckham Co.
ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2003

County of Canyon

City of Caldwell Rural (No. ....., ... St.)

File No. 7626

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME + Robert Rowen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Boy	White	+ S

6. DATE OF BIRTH: + April (Month) 15th (Day) 1914 (Year)

7. AGE: + ... yrs. ..... mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... +
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) + Idaho

10. NAME OF FATHER + Merl Rowen

11. BIRTHPLACE OF FATHER (State or Country) + Kansas

12. MAIDEN NAME OF MOTHER + Augusta Vasold

13. BIRTHPLACE OF MOTHER (State or Country) + Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) + Mrs. A. Vasold
(Address) + Caldwell Idaho

15. Filed April 20 1914 Jo. S. Myers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1914, to April 15 1914, that I last saw h... alive on April 15 1914, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Mullen M. D.

April 20 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill | DATE OF BURIAL: 4/20 1914

20. UNDERTAKER: W. G. Dyer | ADDRESS: Caldwell

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7627

Registered No. 23

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Vinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan. (Month) 12 (Day) 1874 (Year)

7. AGE: 40 yrs. 3 mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: George F. Vinson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Nelson
(Address) Caldwell

15.
Filed April 21 1914 John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 19" (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 8" 1914, to apl. 19" 1914 that I last saw h[illegible] alive on apr. 19" 1914 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Disease of Heart

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Henry M. D.
apr. 21" 1914 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 12 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge — DATE OF BURIAL: Apr 21 1914

20. UNDERTAKER: W C Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2004
File No. 7628
Registered No. 24

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Johnston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W.	Married

6. DATE OF BIRTH
Nov. (Month) 28 (Day) 1887 (Year)

7. AGE
26 yrs. 5 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Keeping
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Huston Frost.

11. BIRTHPLACE OF FATHER (State or Country) Kansas. Nebraska

12. MAIDEN NAME OF MOTHER Matilda Price.

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillie Frost Mitchell
(Address) Boise R. D 2,

15.
Filed April 22 - 1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1914, to April 21 1914, that I last saw her alive on April 21 1914, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Miller M. D.
April 22 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 4-23 1914

20. UNDERTAKER: W. G. Dyer — ADDRESS: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3

County of Canyon Primary Registration District No. 2005

City of Caldwell Rural (No. , St.)

File No. 7129

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nancy Jane Noyes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Sept (Month) 19 (Day) 1844 (Year)

7. AGE: 69 yrs. 7 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penna

10. NAME OF FATHER: Joseph Hiett

11. BIRTHPLACE OF FATHER (State or Country): Dont Knows

12. MAIDEN NAME OF MOTHER: Abigail Noyes.

13. BIRTHPLACE OF MOTHER (State or Country): Dont Knows.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A J Hiett
(Address) Caldwell Idaho

15.
Filed April 26 1914 Jas S. Myers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apl. (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from April 25 1914 to April 25 1914 (Son dead)
that I last saw h.. ~~alive~~ on April 25 1914,
and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Cardiac Asthma

(Duration) 10 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. D. Miller M. D.
April 26 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Apr 26 1914

20. UNDERTAKER: W E Dyer — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3

Primary Registration District No. 2005

File No. 7630

Registered No. 26

1. PLACE OF DEATH.

County of Canyon

City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Henton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: Feb (Month) 10 (Day) 1890 (Year)

7. AGE: 23 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry business, or dstablishment in which employed (or employer): Idaho Trac Co.

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Frank Henton

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Mary A. Baron

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Henton
(Address) Boise Idaho.

15.
Filed April 23 – 1914 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~1914~~, to ..... 191..., that ~~I last saw h~~ alive on ..... 191..., and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Electric Shock from live wire while in the employe of the I R Ct & Power Co
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) (Coroners Verdict)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred K Robin M. D.
4/23/1914. (Address) Nampa. Ida. Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise Idaho	4/24 1914

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 7631
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Elizabeth Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W	Widow

6. DATE OF BIRTH: Oct (Month) 13 (Day) 1837 (Year)

7. AGE: 77 yrs. 5 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentuckey

10. NAME OF FATHER: Benj Powell

11. BIRTHPLACE OF FATHER (State or Country): Kentuckey

12. MAIDEN NAME OF MOTHER: Mary Owens

13. BIRTHPLACE OF MOTHER (State or Country): Kentuckey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs T W Rice
(Address) Caldwell Ida

15. Filed 5/4/1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1914, to May 2, 1914 that I last saw h[illegible] alive on May 1st 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus
Cancer

(Duration) not known yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
5/4 1914 (Address) Caldwell.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: May 4 1914

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Cantr Home
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20 34
Primary Registration District No. 2020
(No. ....., ... St.)

File No. 7632
Registered No. 10
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Susan E Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 13 (Day) 1862 (Year)

7. AGE: 52 yrs. — mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: A J Davidson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Ann Mix

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W R Edwards
(Address) Mt Home

15. Filed April 21st 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1914, to April 20 1914, that I last saw h alive on April 20 1914, and that death occurred on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows: Myocarditis, following Typhoid fever

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Coffman M. D.
4-20 1914 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home — DATE OF BURIAL: April 21st 1914

20. UNDERTAKER: J. M. Cowen — ADDRESS: Mountain Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Mtn Home
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020
(No. ..... St.)

File No. 7633
Registered No. 9
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sedar Simpkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 4 (Day) 827 (Year)

7. AGE: 87 yrs. 2 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): Farm

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: David Simpkins

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: dont Know

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Raeph W. Simpkins
(Address) Mountain Home, Idaho

15. Filed Apr. 4th 11 1914 B. W. Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 3 (Day) 3 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1914 to Apr 3 1914
that I last saw h. im. alive on Apr. 3 1914
and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Oedema — following retention of urine

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. S. Hawley M. D.
4/4 1914 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mtn Home — DATE OF BURIAL: Apr 5 1914

20. UNDERTAKER: J M Cowen — ADDRESS: Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 7634
Registered No. 9
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlotte Townley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Apr (Month) 2 (Day) 1885 (Year)

7. AGE
29 yrs. 10 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Weiser Ida

10. NAME OF FATHER Joseph Campbell.

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Francis Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles W Townley
(Address) Weiser Idaho

15.
Filed 3/3 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 26 1914, to Feby 28 1914
that I last saw her alive on Feby 28 1914
and that death occurred on the date stated above, at 1 1/4 M.
The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Merrill M. D.
4/3 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Weiser Ida — DATE OF BURIAL May 3 1914

20. UNDERTAKER L. C. Northam — ADDRESS Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 763.
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Weiser
Registration District No. 86
Primary Registration District No. 1010.
(No. Weiser Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James Monroe Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 18 (Day) 1861 (Year)

7. AGE: 52 yrs. 8 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of Indiana

10. NAME OF FATHER: — Stephens

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Margaret E. McClury

13. BIRTHPLACE OF MOTHER (State or Country): State of Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. T. Stephens
(Address) Weiser Ida

15.
Filed 3/6 1914
W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 20 1914, to Mar 5th 1914 that I last saw him alive on Mar 5 1914 and that death occurred on the date stated above, at 6.40 P M.

The CAUSE OF DEATH* was as follows:

Appendicetis Gangrenous

(Duration) ..... yrs. ..... mos. 3 7 ds.

Contributory (Secondary) Cholecystetis colon Benefit

(Duration) ..... yrs. ..... mos. 1 6 ds.

(Signed) [signature] M. D.

Mar 10 1914 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Galloway Cemetery — DATE OF BURIAL: 3/7 1914

20. UNDERTAKER: R. W. Bowen — ADDRESS: Weiser.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7636
Registered No. 11

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 1010
City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William J. Kirby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) – 12 (Day) – 1834 (Year)

7. AGE: 79 yrs. 7 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stage Driver
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mc Connellsville; Ohio

10. NAME OF FATHER: John Kirby

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Prudence Seaman

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Lapish
(Address) Weiser Ida

15.
Filed 3/6 1914 E. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) – 6 (Day) – 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1913, to Mar 6 1914
that I last saw him alive on Mar 6 1914
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Cancer (Stomach)

..... (Duration) — yrs. 4 mos. — ds.

Contributory (Secondary) ..... (Duration) ..... mos. ..... ds.

(Signed) C. A. Shirley M. D.
3/6 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser
DATE OF BURIAL: March 7 1914

20. UNDERTAKER: A. G. Cordelle
ADDRESS: Weiser; Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2002
(No. ....., ... St.)

File No. 763
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kate Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Sept 26 1857 (Month) (Day) (Year)

7. AGE: 56 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): .....

10. NAME OF FATHER: Cassimer Bow

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Lucinda Watts

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Mitchell
(Address) Weiser Ida.

15.
Filed 3/14 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 13 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1913, to Mar 13 1914
that I last saw her alive on Mar 13 1914
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy,
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. M. Mitchell M. D.
Mar 14 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida
DATE OF BURIAL: Mar 15 1914

20. UNDERTAKER: [illegible]
ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17149

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser (No....., ...St.)

Registration District No. 86
Primary Registration District No. 2112

File No. 763
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barbara Caldwell Mailer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed
6. DATE OF BIRTH: December (Month) 27th (Day) 820 (Year)
7. AGE: 93 yrs. 2 mos. 21 ds.
IF LESS than 1 day how many.....hrs. or .....min?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Peneycook, Scotland
10. NAME OF FATHER: David Caldwell
11. BIRTHPLACE OF FATHER (State or Country): Aucterairden, Scotland
12. MAIDEN NAME OF MOTHER: Elizabeth Nesbit
13. BIRTHPLACE OF MOTHER (State or Country): Aucterairden, Scotland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hortense A Ford
(Address) Weiser Idaho
15.
Filed 3/19 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 1 (Month) (Day) 191.. (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191.., to ..... 191..
that I ~~last saw~~ did not see her alive on ..... 191..
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Senility
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. B. Hartley M. D.
March 18 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Weiser
DATE OF BURIAL: 3/18 1914
20. UNDERTAKER: A. F. Cordelle
ADDRESS: Weiser

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser
Registration District No.
Primary Registration District No.
(No. East Main St.)
File No. 16
Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Martha A. Dickerson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: June — — 1847 (Month) (Day) (Year)

7. AGE: 71 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Independence, Missouri

10. NAME OF FATHER: F. L. Greenwood

11. BIRTHPLACE OF FATHER (State or Country): Mercy B., Ky.

12. MAIDEN NAME OF MOTHER: Martha Letter

13. BIRTHPLACE OF MOTHER (State or Country): London, England, G. B.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. M. Dickerson
(Address) Weiser, Idaho

15.
Filed 3/20 1914
W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March — 18 — 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1914, to Mch 18 1914 that I last saw h er alive on 16th March 1914 and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) 1½ yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.
Mch 20 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser, Ida.
DATE OF BURIAL: 3/21 1914

20. UNDERTAKER: R. W. Bowen
ADDRESS: Weiser

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

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Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 764
Registered No. 16

1. PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 86
Primary Registration District No. 1010
(No. West Commercial St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Anna Christenson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: November 23 1875 (Month) (Day) (Year)
7. AGE: 38 yrs. 4 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Cardiff, Wales, G. B.
10. NAME OF FATHER: John Rees,
11. BIRTHPLACE OF FATHER (State or Country): England, G. B.
12. MAIDEN NAME OF MOTHER: Emily Lawson
13. BIRTHPLACE OF MOTHER (State or Country): Cardiff, Wales, G. B.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto Christenson
(Address) Weiser Ida
15.
Filed 4/4 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 31 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 25 1914, to Mar 31 1914 that I last saw her alive on Mar 31st 1914 and that death occurred on the date stated above, at 1:30 P. M.
The CAUSE OF DEATH* was as follows:

Paramonia
Paranoia
(Duration) yrs. 1 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) [signature] M. D.
4/3/1914 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: ~~Weiser~~ Payette, Idaho — DATE OF BURIAL: April 5 1914
20. UNDERTAKER: R. W. Bowen — ADDRESS: Weiser, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. ..... ; St.)

File No. 764
Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hallie Belle Bryandeus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Wht	Married

6. DATE OF BIRTH: Sept (Month) 28 (Day) 1877 (Year)

7. AGE: 37 yrs. 6 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: David McClure

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Amanda Williams

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) [illegible]

15.
Filed 4/15 1914 M. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to Apr 17 1914, that I last saw her alive on Apr 17 1914, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Pericarditis

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Conner E. Conant, M. D.
4/18 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: 4/19 1914

20. UNDERTAKER: L. L. Northern — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 764
Registered No. 18

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 56
County of Washington Primary Registration District No. 2112
City of Weiser (No. 15 mi N. of Weiser on Payne Creek St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ina Alice Robertson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November 4 1 (Month) (Day) (Year)

7. AGE: 56 yrs. 5 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cass Co., Missouri

10. NAME OF FATHER: John Fox

11. BIRTHPLACE OF FATHER (State or Country): State of Penn.

12. MAIDEN NAME OF MOTHER: Mandy McSpaden

13. BIRTHPLACE OF MOTHER (State or Country): State of Penn.

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Fox
(Address) R.F.D. #1 Weiser, Idaho

15.
Filed 4/30 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1914, to April 28 1914
that I last saw her alive on April 28 1914
and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:
Spotted fever,

(Duration) yrs. X mos. 15 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Houston E. Snyder M. D.
April 30 1914 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mann Ck Cemetery — DATE OF BURIAL: May 1 1914

20. UNDERTAKER: R. W. Bowen — ADDRESS: Weiser, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7644

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Kimberly

Registration District No. 37

Primary Registration District No. 2085

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Cecilia Homan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 25 (Day) 1863 (Year)

7. AGE 50 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Thomas Fanning

11. BIRTHPLACE OF FATHER (State or Country) Kilcany Co. Ireland

12. MAIDEN NAME OF MOTHER Bridget Burne

13. BIRTHPLACE OF MOTHER (State or Country) Kilcany Co. Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. L. Homan

(Address) Kimberly, Ida.

15. Filed 2-15 1914

James L. Engleton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1913 to after death 1914, that I last saw h alive on Jan 30 1914 and that death occured on the date stated above, at about 10:30 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy Judging from Symptoms as reported after Death

(Duration) ..... Yrs. Few hours mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.

2/17 1914 (Address) Kimberly, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stat MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls — DATE OF BURIAL 2-16 1914

20. UNDERTAKER C J Crosby — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls.
City of Hailister.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 87
Primary Registration District No. 2085
(No. ....., ... St.)

File No. 761
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Theresa Moudag.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widow
6. DATE OF BIRTH: Oct. (Month) 22 (Day) 1835 (Year)
7. AGE: 78 yrs. 4 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Attendorn, Germany
10. NAME OF FATHER: Joseph Graf.
11. BIRTHPLACE OF FATHER (State or Country): Attendorn, Germany
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Burrows
(Address) Hollister Idaho.
15. Filed 2-24 1914 W. A. Farrell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 22 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1914, to Feb. 22 1914, that I last saw her alive on Feb. 21 1914, and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Cancer of the Breast.
(Duration) ..... yrs. 8 mos. X ds.
Contributory (Secondary) .....
(Duration) X yrs. X mos. X ds.
(Signed) W. A. Farrell M. D.
Feb. 23 1914. (Address) Hollister, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. DATE OF BURIAL: Feb. 24 1914
20. UNDERTAKER: J. F. Saunders ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ....., ... St.)

File No. 761
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number. .....

2. FULL NAME H. J. Whitaker

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): [illegible]

6. DATE OF BIRTH: Sept (Month) 21" (Day) 1860 (Year)

7. AGE: 53 yrs. 5 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Near Shelbina State of Missouri

10. NAME OF FATHER: H. J. Whitaker

11. BIRTHPLACE OF FATHER (State or Country): No. Carolina

12. MAIDEN NAME OF MOTHER: Laura Gillespie

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia J. Whitaker
(Address) Peronanley Higginsville Mo
Caldwell Near Buhl Idaho

15.
Filed 3-4 191 11
John Eagles
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 1st (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Suicide with Shot gun

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Charles J Crosby M. D. Coroner
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Near Clinton Missouri DATE OF BURIAL 3/6 1914

20. UNDERTAKER C J Crosby ADDRESS Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 761

Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 2085
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Schuh

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: March (Month) 7 (Day) 1897 (Year)

7. AGE: 20 yrs. mos. 13 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wm Schuh

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Alice Miller

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Schuh
(Address) Twin Falls Ida RFD #1

15. Filed 3-20 1914 John L Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: mch (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from mch 15 1914, to mch 19 1914
that I last saw h~~is~~ alive on mch 16 1914
and that death occurred on the date stated above, at 2 30 ~~a~~ p M.

The CAUSE OF DEATH* was as follows:
Endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Morgan M. D.
Mar 19 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 3-21 1914

20. UNDERTAKER: Chas J Crosley
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

File No. 764

County of Twin Falls

City of " "

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald Showalter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Sept 3rd (Month) (Day) 1905 (Year)

7. AGE: 8 yrs. 6 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: C. E. Showalter

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Jennie L. Drumheller

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Showalter
(Address) Filer Idaho

15.
Filed 3-8 1914 Johnnie Coghlan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21 1914, to Mar. 7 1914, that I last saw him alive on Mar. 7 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Bronchial

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) Measles

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Morgan M. D.

Mar. 7 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Mar 8 1914

20. UNDERTAKER	ADDRESS
Chas. J. Crosby	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to the registrar of Vital Statistics)

Death Certificate No. 7648

Name Donald Showalter

Date of Death Mar. 7, 1914.

Cause of Death Broncho Pneumonia

Contributary Cause of death Measles

(Sign here) J. R. Morgan M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. , St.)

File No. 7649
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hubert Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH June 1st 1907
(Month) (Day) (Year)

7. AGE 6 yrs. 10 mos. 8 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Wm Baker

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Flowerdew

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. M. Baker
(Address) Twin Falls

15.
Filed 3-9 1914
John W. Eagleston
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mch 8 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2 1914, to 3/8 1914, that I last saw h im alive on 3/8 1914 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia Broncho

(Duration) yrs. mos. 7 ds.
Contributory Measles
(Secondary)
(Duration) yrs. mos. ds.

(Signed) C. D. Weaver M. D.
19 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days.
In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls
DATE OF BURIAL 3-9 1914

20. UNDERTAKER C J Grasty
ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7649

Name Hubert Baker

Date of Death Mar. 8, 1914.

Cause of Death [illegible]

Contributary Cause of death

(Sign here) _____ M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 765
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Ued Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: July (Month) 13 (Day) 1881 (Year)

7. AGE: 32 yrs. 7 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: George E Willson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Willson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ued R Smith
(Address) Twin Falls

15.
Filed 3-10 191 4 John A Gyllen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
3 (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/9/1914, to 3/9/1914, that I last saw her alive on 3/7 1914, and that death occurred on the date stated above, at 6 4 M.

The CAUSE OF DEATH* was as follows:
Septic endometritis, due to abortion

(Duration) ..... yrs. ..... mos. Four ds.
Contributory (Secondary) Septic thrombus of brain

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Tisley M. D.
3/10 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 3/10 1914

20. UNDERTAKER: C. F. Isaman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 7085
(No. ..... St.)

File No. 7651
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lyle G. Thompson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Dec. 20 1905
(Month) (Day) (Year)

7. AGE: 8 yrs. 7 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: L. C. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alta L. Rawson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Warner
(Address) Twin Falls Idaho

15. Filed Mar. 16 1914 Johnson Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 14 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1914 to Mar. 14 1914 that I last saw h[illegible] alive on Mar 14 1914 and that death occurred on the date stated above, at 1:35 P.M.

The CAUSE OF DEATH* was as follows:
Fracture of base & vault of skull. Thrown from pony.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Johnson Coughlin M. D.
3-15 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 3-16 1914

20. UNDERTAKER: Chas. J. Crosby
ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 7652
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin Virgil Givans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH
Mar (Month) 8 (Day) 1912 (Year)

7. AGE
2 yrs. mos. 10 ds.
IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oklahoma

10. NAME OF FATHER Cadrian M. Givans

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Nellie E Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. L. Nelson
(Address) Twin Falls Ida

15.
Filed 3-18 1914 John Engelke
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 18th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 3 30 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Measles
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Crosby M. D.
19.... (Address) ..... Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Twin Falls
DATE OF BURIAL 3-19 1914

20. UNDERTAKER C J Crosby
ADDRESS Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 765
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Velma Audrey Neill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	Wht.	

6. DATE OF BIRTH: Nov. 5th 1910 (Month) (Day) (Year)

7. AGE: 4 yrs. 4 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: W. D. Neill

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Rosia Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Neill
(Address) Eden Ida

15. Filed 3-19 1914 John Engleman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 19 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21 1913, to March 19 1914, that I last saw her alive on March 19 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Tubarculer Meningetis

(Duration) ..... yrs. ..... mos. 17 ds.
Contributory (Secondary) Potts Disease
(Duration) 4 yrs. 9 mos. ..... ds.
(Signed) J. H. Sawyer M. D.
3/19 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 3-20 1914

20. UNDERTAKER: Chas. F. Cooley
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 765
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William J. Wilkinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widower

6. DATE OF BIRTH: Feb. (Month) ..... (Day) 1855 (Year)

7. AGE: 59 yrs. 4 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: John Wilkinson

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Wilkinson

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Craig Wilkinson
(Address) Athena Oregon

15. Filed Mar 20 191[illegible] John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1914, to Mar 20 1914, that I last saw h[illegible] alive on Mar 19 1914, and that death occurred on the date stated above, at 5.30 M.

The CAUSE OF DEATH* was as follows:
Dysentery from
Catarrhal Jaundice
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John T. Coughlin M. D.
3/20 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Echo Oregon | DATE OF BURIAL: 1914

20. UNDERTAKER: F. J. Grossman | ADDRESS: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 765
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruby G. Muir

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	Married

6. DATE OF BIRTH: Sept. (Month) 15 (Day) 1886 (Year)

7. AGE: 27 yrs. 6 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Chas. W. Gulette

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mapes

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Muir
(Address) Twin Falls Ida.

15. Filed 3/19 1914 John H Engleman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1914, to Mar. 18 1914, that I last saw h er alive on Mar 18 1914, and that death occurred on the date stated above, at P M.

The CAUSE OF DEATH* was as follows:
Tuberculous peritonitis

(Duration) 4 yrs. 7 mos. ds.
Contributory (Secondary): T.B. of Pleurisy - lung - liver
(Duration) yrs. 3 mos. ds.

(Signed) J. R. Morgan, M. D.
Mar 21 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 3/21 1914

20. UNDERTAKER: J. F. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 765
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter F. Recob.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec (Month) 24 (Day) 1864 (Year)

7. AGE: 45 yrs. 2 mos. 27 da.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Josephus Recob.

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Rachel Franklin

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rex
(Address) Twinfalls Idaho

15. Filed Mar 24 1914 Johnet Eagleby, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March. (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 22 1914, to March. 21 1914, that I last saw her alive on March. 21 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Cholecystitis
(Gall bladder drained)
(Duration) 11 yrs. mos. ds.
Contributory (Secondary) Post operative vomiting.
(Duration) — yrs. — mos. 3 ds.
(Signed) J. H. Wilson M. D.
March. 24 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. DATE OF BURIAL: 3/24 1914

20. UNDERTAKER: J. J. Freeman ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form [redacted] 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. [redacted] OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... , ... St.)

File No. 765
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion Binnie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Widow or Widower)

6. DATE OF BIRTH: November 28 1833 (Month) (Day) (Year)

7. AGE: 80 yrs. 4 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry business, or establishment in which employed (or employer): retired

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: James McMillan

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Marion McDugal

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James McMillan
(Address) Twin Falls Ida

15. Filed Mar 27 1914 John F Engleden Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 26 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1913, to March 26 1914, that I last saw h[illegible] alive on March [illegible] 1914, and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Wilson M. D.
March 26 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 3/27 1914

20. UNDERTAKER: J J Goodman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 765

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Ax

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Aug. (Month) 28 (Day) 1837 (Year)

7. AGE: 76 yrs. 7 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: John B. Ax.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Chalotta —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Simon J. Ax
(Address) Twin Falls, Ida.

15. Filed Mar 30 1914 John R. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 28 1914, to Mch 29 1914, that I last saw h[illegible]live on Mch. 28 1914 and that death occurred on the date stated above, at 2.45 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Bronchio

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Wurdeman M. D.

Mch. 29 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver Colorado | DATE OF BURIAL: 4/2 1914

20. UNDERTAKER: J. J. Goodman | ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 1976O

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7658

Name John Ax

Date of Death 3-29-14

Cause of Death Broncho Pneumonia

Contributary Cause of death

(Sign here) H.W. Wilson M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of " "

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 765

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Turbeaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 10th (Day) 1861 (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: John Turnbaugh

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mcdonnen

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Byron Everett

(Address) Filer Ida.

15. Filed 4-1 1914

John H Coghlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 29 1914, to Mar. 30 1914, that I last saw him alive on Mar 30 1914, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gall Stone

..... (Duration 3 yrs. ..... mos. ..... ds.

(Signed) J. R. Morgan M. D.

Mar 30 1914 (Address) Twin Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Ida — DATE OF BURIAL: 4-1 1914

20. UNDERTAKER: Chas J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Hatch
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048
(No. ....., ... St.)

File No. 706
Registered No. 20
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bert Russel Higginson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 6 (Day) 1912 (Year)

7. AGE: 1 yrs. 6 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hatch Ida

10. NAME OF FATHER: Nairn Higginson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Carrie Dutton

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence Dutton
(Address) Alexander. Ida.

15. Filed Mar 10 1914 Eric Kaeppler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ no physician in 191, to 191, ~~that I last saw h alive on~~ attendance 191, ~~and~~ that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Dead

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Smith M. D.

3/1 1914 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cherkefield — DATE OF BURIAL: March 1914

20. UNDERTAKER: Hans Johnson — ADDRESS: Preston

SYMS - YORK CO., ETRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Bancroft
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2648
(No. ____, ____ St.)

File No. 7661
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Schneider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May 10 (Month) (Day) 1851 (Year)

7. AGE: 62 yrs. 9 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Jacob Schneider

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Burns
(Address) Bancroft Ida

15.
Filed March 10, 1914 Ellis Bagley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1914, to Feb 10 1914, that I last saw her alive on Feb 9 1914 and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 0 yrs. mos. 2 ds.

Contributory (Secondary) Rheumatism

(Duration) 0 yrs. mos. ds.

(Signed) H. J. Smith M. D.

Feb 20 1914 (Address) Bancroft.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lund. DATE OF BURIAL: Feb 12, 1914

20. UNDERTAKER: Ras Johnson ADDRESS: Bancroft

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No. 766
Registered No. 24

1. PLACE OF DEATH.
County of Bannock
City of Bancroft
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Floyd Rigby
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 21 1900 (Month) (Day) (Year)

7. AGE: 13 yrs. 10 mos. 10 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Aaron Rigby

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Susie Burke

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Rigby
(Address): Bancroft

15. Filed April 10, 1914 Ellis Kay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 30 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29 1914, to Mar 30 1914, that I last saw h[illegible] alive on Mar 30 1914, and that death occurred on the date stated above, at 1a M.

The CAUSE OF DEATH* was as follows:

Cerebral Rheumatism

(Duration) yrs. mos. 4 ds.

Contributory (Secondary) Scarlet fever

(Duration) yrs mos. 10 ds.

(Signed) P. J. Smith M. D.

April 1914 (Address) Bancroft.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bancroft — DATE OF BURIAL: April 2, 1914

20. UNDERTAKER: [illegible] Lamond — ADDRESS: Bancroft

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 12 7664
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Meridian (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant McGrath

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May 3 (Month) (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. / ..... ds.
IF LESS than 1 day how many. 6 ...hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ralph McGrath

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Daisy Hughbanks

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. W. McGrath
(Address) RFD #1,

15. Filed 3 – 5 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/3 1914, to 3/4 1914, that I last saw him alive on 3/4 1914, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Prematurity Birth
.....
.....
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.

(Signed) Fred A. Tatum M. D.
3/6 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dry Creek	May 5-1914
20. UNDERTAKER	**ADDRESS**
Frey & Summers	Boise Id

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 13466

County of Ada

City of Boise (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John E Yates

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
male	White	~~Write the word~~ Married

6. DATE OF BIRTH

7 February 1845
(Month) (Day) (Year)

7. AGE

69 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Capitalist

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER George Yates

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER Sophia Blunt

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. O. Sawyer

(Address) Boise, Idaho

15.

Filed 3 - 4 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/1 1914, to 3/4 1914, that I last saw ~~him~~ alive on 3/3 1914 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Aneurism Aorta (Thoracic)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Peters M. D.

3/5 1914 (Address) Tuck Bldg

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Portland Oregon

DATE OF ~~BURIAL~~ Shipment: Mar 6 1914

20. UNDERTAKER: Schreiber & Siedenfrau

ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 14
Registered No. 765

1. PLACE OF DEATH.
County of Ada
City of Mountain Home (No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin T. Chase

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 16 (Day) 1830 (Year)

7. AGE: 83 Yrs. 6 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Amos Chase

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Molly Smith

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. H. Burnett
(Address) Soldiers Home

15. Filed 3-10 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to 3/8 1914, that I last saw him alive on 3/7 1914, and that death occured on the date stated above, at 9A M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Senility
(Duration yrs. mos. ds.

(Signed) Fred J. Tidwell M. D.
3/8 1914 (Address) Lab Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 10 1914

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & CORS. 24658

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7666

Name Benjamin F. Chase (Soldiers' Home)

Date of Death Mar. 8, 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) Fred. T. Lathrop M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 15
Registered No. 765

1. PLACE OF DEATH.
County of Ada
City of near Boise
(No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John T Riordan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: 4 30 1830 (Month) (Day) (Year)
7. AGE: 84 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: not Obtainable
11. BIRTHPLACE OF FATHER (State or Country): ~~not~~ Ireland
12. MAIDEN NAME OF MOTHER: not Obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John E Riordan
(Address) Boise Idaho
15.
Filed 3 — 14 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 13 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3/1 1914 to 3/13 1914, that I last saw h am alive on 2/13 1914 and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Fred A Fitzgerald M. D.
3/14 1914 (Address) Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ..... yrs. ..... mos. 18 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? In Boise 2 Years
Former or usual residence Idaho City Idaho

19. PLACE OF BURIAL OR REMOVAL: Idaho City Idaho — DATE OF BURIAL: 3/16 1914
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 16
Registered No. 266

1. PLACE OF DEATH.
County of Ada
City of Near Boise (No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. Thomas

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): American

6. DATE OF BIRTH. Nov (Month) 11 (Day) 1845 (Year)

7. AGE 68 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER David Thomas

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Margret Wallace

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Martin McGrath
(Address) Thermopolis Wyo

15.
Filed 3-17 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/13 1914, to 3/15 1914, that I last saw him alive on 3/15 1914 and that death occured on the date stated above, at 10 30 P. M.

The CAUSE OF DEATH* was as follows: ~~Uremia~~ Chronic Brights

(Duration) Yrs 2 mos. ds.
Contributory (Secondary) Chronic Brights Disease
(Duration yrs 2 mos ds.
(Signed) Fred A Tuttle M. D.
3/17 1914 (Address) Boise Idg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thermopolis Wyo | DATE OF BURIAL: Mar 20 1914

20. UNDERTAKER: Terry & Summers | ADDRESS: Boise Idg

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 711 Idaho St.)

File No. 53 1914

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wong Do Toy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
male	Yellow	Widower (the word.)

6. DATE OF BIRTH Not obtainable 1849
(Month) (Day) (Year)

7. AGE 63 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Retired

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (State or Country) U C

12. MAIDEN NAME OF MOTHER U G

13. BIRTHPLACE OF MOTHER (State or Country) U U

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wong Toy

(Address) Dantzel

15.

Filed 3 – 5 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 25 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1913, to Jan 10 1914, that I last saw h alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Calvert M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence China Temple Idaho St

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hong Kong China	3/5 191

20. UNDERTAKER	ADDRESS
Schreiber & Eidenfaden	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5-5-7670

Registered No. _____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1609 N. 12th St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Allen Myers

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH Oct (Month) 3rd (Day) 1904 (Year)

7. AGE 9 yrs. 5 mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Student

(b) General nature of industry business, or dstablishment in which employed (or employer) Washington School Boise, Ida.

9. BIRTHPLACE (State or Country) Reno. Nev

10. NAME OF FATHER Jacob L. Myers

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Minnie Berner

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J E Myers

(Address) _____

15.

Filed 3 – 7 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 6th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~May 26~~ 1914 to March 6 1914

that I last saw him alive on March 6 1914

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) _____

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W S Richey M. D.

March 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? _____

Former or usual residence 1609 N. 12th St Boise

19. PLACE OF BURIAL OR REMOVAL St Johns Cemetery **DATE OF BURIAL** 3/8 1914

20. UNDERTAKER Schreiber & Siebenfaden **ADDRESS** Boise Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 56
Registered No. 765

PLACE OF DEATH.

County of Ada
City of Boise
(No. 1803 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Margaret O'brien.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Single.

6. **DATE OF BIRTH** Oct 25th (Month) (Day) 1895 (Year)

7. **AGE** 18 yrs. 4 mos. 12 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.?*

8. **OCCUPATION**
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Saline, County Kansas.

10. **NAME OF FATHER** Martin O'brien

11. **BIRTHPLACE OF FATHER** (State or Country) Salina, Kansas.

12. **MAIDEN NAME OF MOTHER** Allie Stanley

13. **BIRTHPLACE OF MOTHER** (State or Country) Sakenda, Eugene Co. Mo.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) C G Allen
(Address) 1803 Idaho St

15.
Filed March 9th 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** March 8 1914
(Month) (Day) (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from Jan 3rd 1914, to March 8 1914, that I last saw her alive on March 8 1914, and that death occurred on the date stated above, at 9:45 a. M.

The CAUSE OF DEATH* was as follows:
Amyloid disease due to hereditary syphilis.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maurice Henry Tallman M. D.
3/9 1914 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cemetery | **DATE OF BURIAL** March 9 1914

20. **UNDERTAKER** Schreiber & Sidenfaden | **ADDRESS** Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. B 7672
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1721 N 8 St St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar (Month) 7 (Day) 1914 (Year)

7. AGE ... Yrs. ... Mos. ... ds.
IF LESS than 1 day how many 4 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER S C Johnson

11. BIRTHPLACE OF FATHER (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Ida Ramsey

13. BIRTHPLACE OF MOTHER (State or Country) Wash Wash Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S C Johnson
(Address) 1721 N 8 St

15. Filed 3-9 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 7 1914, to Mch 7 1914, that I last saw h[illegible] alive on Mch 7 1914, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(Duration) ... Yrs. ... mos. 6 hrs. ... ds.

Contributory (Secondary)
(Duration) ... Yrs. ... mos. ... ds.

(Signed) C W Bayer M. D.
Mch 9 1914 (Address) 708 Sonna Blg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: Mch 9 1914

20. UNDERTAKER: Troy & Summers — ADDRESS: Boise Idg

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 68 7254
Registered No. 60

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410, State St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louisa Pfaser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 6 (Day) 1851 (Year)

7. AGE: 62 yrs. 8 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Hanover, Austria Germany

10. NAME OF FATHER: Fredrick Steinhoff

11. BIRTHPLACE OF FATHER (State or Country): Austrodia Hanover

12. MAIDEN NAME OF MOTHER: Johonnah Weidemeier

13. BIRTHPLACE OF MOTHER (State or Country): Hanover.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Paser
(Address) Boise

15. Filed 3—10 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 9th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1914 to March 9 1914 that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Brights disease
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos Calvert M. D.
..... 19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weehawken N.J. | DATE OF BURIAL: 3/12 1914

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 62

Registered No. 7674

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie D. Tingley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Nov 21 (Month) (Day) 1887 (Year)

7. AGE: 27 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Thomas Maines

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Helen Curry.

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. L. Tingley

(Address) Boise Idaho

15. Filed 3-14 1914 M S Parker Docal Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jet 4 1914, to Mch 12 1914, that I last saw h[illegible] alive on Mch 12 1914 and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Pyemia

(Duration) Yrs. mos. 35 ds.

Contributory (Secondary) Peritonitis

(Duration — yrs. mos. 35 ds.

(Signed) D W Toomey M. D.

3/13 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: Mar 14 1914

20. UNDERTAKER: Fry & Summers. — ADDRESS: Boise Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 410, State St.)

File No. 63 767
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Bartlett Moss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
November 29 1849
(Month) (Day) (Year)

7. AGE
64 yrs. 3 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Banker
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER James Moss

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Mary Carter

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frederick B Moss
(Address) Payette Idaho

15.
Filed March 15th, 1914 M. D. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 14 1914.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1914., to March 14 1914, that I last saw him alive on March 14 1914, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Calvert M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 6 days. In the State 23 yrs. — mos. — days.
Where was disease contracted if not at place of death?
Former or usual residence Payette Idaho

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: March 17 1914

20. UNDERTAKER: Schreiber & Hedinger
ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise (No. 410, State St.)

File No. 6574

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank E. Lewis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 2nd (Day) 1888 (Year)

7. AGE: 26 yrs. 0 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Waiter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Butte, Mont

10. NAME OF FATHER: Geo Lewis

11. BIRTHPLACE OF FATHER (State or Country): not obtainable

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs F. E. Lewis

(Address) 506 S. 4th St Boise

15.

Filed 3-18 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1914, to March 16 1914, that I last saw h[illegible] alive on March 15 1914 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Emphysema & General Debility

(Duration) yrs. mos. 16 ds.

Contributory (Secondary) Appendicitis

(Duration) yrs mos. 4 ds.

(Signed) W S Peters M. D.

3/17 1914 (Address) Boise.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/18 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Mr. Peters

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 7 & Myrtle St.)

File No. 6676

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ethel Arbelle Gamell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May 5th 1914 (Month) (Day) (Year)

7. AGE: ___ yrs. ___ mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Ben Gamell

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Cora Hagemann

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ben Gamell

(Address)

15. Filed 3/18 1914 W. S. Parker Local Registrar

Glaze

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 17th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-5 1914 to 3-17 1914, that I last saw her alive on 3-16 1914, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (Secondary)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. K. Glaze M. D.

19___ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence: 7 & Myrtle

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery Ada County Plot — DATE OF BURIAL: 3/19 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67 7678

Registered No.

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 723, Ada St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth A. Mullany

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 14 (Day) 1866 (Year)

7. AGE: 47 yrs. 6 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Geo. Turner

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sophia Royce

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Mullany
(Address) Boise

15.
Filed 3/21 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
3 (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19 1913, to 3/19 1914, that I last saw her alive on 3/19 1914, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Diabetis Mellitus

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Fred A Pettengill M. D.
3/19 1914 (Address) Lake Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/21 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. ....., ... St.)

File No. 7176
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) 8 (Day) 70 (Year)

7. AGE: 43 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R S Ewart
(Address) Boise

15.
Filed 3-24 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 21st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1913 to March 21 1914, that I last saw h.... alive on March 21 1914 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Tubercular Peritonitis
..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) R S Ewart M. D.
19.... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Mar 25 1914

20. UNDERTAKER: Deweese & Hodenpool
ADDRESS: Boise

BYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. ....., ... St.)

File No. 734 (illegible)

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James J Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH

Unknown 1807
(Month) (Day) (Year)

7. AGE

107 yrs. Unknown mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lgandner

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Falk

(Address) Boise Idaho

15.

Filed 3-28 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 27, 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1913 to Mar 27 1914, that I last saw h.m alive on Mar 26 1914, and that death occurred on the date stated above, at A.M.

The CAUSE OF DEATH* was as follows: —

Old age
Complication
Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Falk M. D.

3/27 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	3/29 1914

20. UNDERTAKER	ADDRESS
Scherbel & Sidenfaden	Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7682
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Lanark

Registration District No. 33
Primary Registration District No. 2032
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen L. Sims

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH: April 17 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Boy
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bear Lake

10. NAME OF FATHER: Glen Sims

11. BIRTHPLACE OF FATHER (State or Country): Bear Lake Co.

12. MAIDEN NAME OF MOTHER: Martha Parker

13. BIRTHPLACE OF MOTHER (State or Country): Lanark Bear Lake Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur F Parker
(Address) Lanark Idaho

15. Filed 4/15 1914 R. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 17 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 1914, to April 17 1914
that I last saw him alive on April 17 1914
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Failure of pneumonia
Congestion

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. J. Cutler M. D.
..... 19..... (Address) Lanark Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lanark — DATE OF BURIAL: 4/18 1914

20. UNDERTAKER: Arthur F Parker — ADDRESS: Lanark Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53

Primary Registration District No.

File No. 7681

Registered No.

1. PLACE OF DEATH.

County of Bear Lake

City of St Charles

(No. , St.)

If death occurs away from usual residence give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Alvera Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 12 (Day) 1914 (Year)

7. AGE 13 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer) At School

9. BIRTHPLACE (State or Country) St Charles Bear Lake, Co. Idaho

10. NAME OF FATHER Edmund Johnson

11. BIRTHPLACE OF FATHER (State or Country) St Charles, Idaho

12. MAIDEN NAME OF MOTHER Natallie Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Ovid, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E Fe Peugnine

(Address) St Charles

15. Filed Apl. 16 1914 John Mattson Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1914, to April 12 1914, that I last saw her alive on April 12 1914 and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis following
Aspesis dicitis, Typhoid
Abscess in Right Iliac Region

(Duration) 0 Yrs. 0 mos. 9 ds.

Contributory (Secondary) Peritonitis

(Duration 0 yrs. mos. 13 ds.

(Signed) R. D. Sutton M. D.

(Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL Apr 15 1914

20. UNDERTAKER J. A. Blade | ADDRESS St Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5-5
Primary Registration District No.
(No. , St.)

File No. 768
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph W. Linford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 30 (Day) 1842 (Year)

7. AGE: 71 yrs. 11 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer (retired
(b) General nature of industry business, or dstablishment in which employed (or employer): 4 years)

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Linford

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Maria Christian

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Linford Jr
(Address) St. Charles. Ida.

15.
Filed ..... 1914 John Mattson.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2/ 1914, to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm L. Rich M. D.
1914 (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Charles Ida | DATE OF BURIAL: Mar. 24 1914

20. UNDERTAKER: J. A. Blade | ADDRESS: St Charles

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7686
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loren Aman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Mar 1 (Month) 1 (Day) 913 (Year)

7. AGE: 1 yrs. ..... mos. 12 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Filer Ida

10. NAME OF FATHER: Burt Aman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Sophia Barbezat

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burt Aman
(Address) Filer Ida

15. Filed 3/17 191 4 A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 12 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17 191 4, to Mar 11 191 4
that I last saw h~~im~~er alive on Mar 11 191 4
and that death occurred on the date stated above, at 12 15 M.

The CAUSE OF DEATH* was as follows:

Meningitis (Pneumococcic
secondary to Capreary Bronchitis

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) A A Newberry M. D.
3-15 191 4 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Filer Cemetery
DATE OF BURIAL: 3-13 191 4

20. UNDERTAKER ✓
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7687

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Filer

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benj C. Schlatter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH. June 28 (Month) (Day) 1854 (Year)

7. AGE: 59 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Schlatter

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Christner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J E Schlatter

(Address) Filer Idaho.

15.

Filed ..... 191.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 21 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20. 1914, to April 21 1914, that I last saw h.. alive on April 21 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm E Allen D.O. M.D.

4/21/1914 (Address) Filer, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Kearney Nebr

DATE OF BURIAL ..... 191.....

20. UNDERTAKER: C J Crosby

ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & ENGS. 24658

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7687

Name Benj. C. Schlatter

Date of Death April 21, 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) Wm E. Allen D.O. ~~M.D.~~

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 76[illegible]

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Filer Ida

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Harry Spurgin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 28 (Day) 1911 (Year)

7. AGE ..2.. Yrs. ..6.. Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

9. BIRTHPLACE (State or Country) Sandyville Ia

10. NAME OF FATHER Leo Spurgin

11. BIRTHPLACE OF FATHER (State or Country) Sandyville Ia

12. MAIDEN NAME OF MOTHER Ora Caldwell

13. BIRTHPLACE OF MOTHER (State or Country) Sandyville Ia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leo Spurgin

(Address) Pleasantville Ia

15. Filed 4/12 1914 A A Newberry Local Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 M 4/11, 1914, to 10 AM 4/12 1914, that I last saw h[illegible] alive on 4/11 1914, and that death occured on the date stated above, at 1.30 M.

The CAUSE OF DEATH* was as follows:

Probably Septicemia and Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Lutz M. D.

19.... (Address) Filer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Sandyville Ia — DATE OF BURIAL ..... 191..

20. UNDERTAKER: Chas J Crosby — ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier

Registration District No. [illegible] 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 7689
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Anna Kunzler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: May (Month) 27 (Day) 1846 (Year)

7. AGE: 67 yrs. 10 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Saint Gallen Switzerland

10. NAME OF FATHER: John Geiger

11. BIRTHPLACE OF FATHER (State or Country): Sevelan Switzerland

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. John Kunzler
(Address) Montpelier Ida.

15.
Filed April 15th 1914 — H. H. Kelsey M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1914, to April 13 1914
that I last saw her alive on April 13 1914
and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:

Arterial Sclerosis
Complications

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Unknown
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
..... 19 ..... (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 31 yrs. ..... mos. ..... ds.
In the State 31 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Switzerland

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho
DATE OF BURIAL: April 16th 1914

20. UNDERTAKER: Nelson
ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 7691
Registered No. 46

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dell N. Poirier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1911 (Year)

7. AGE: 3 yrs. 2 mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Coeur D' Alene

10. NAME OF FATHER Napoleon Poirier

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Fanny J. McDonald

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Napoleon Poirier
(Address) .....

15. Filed 3-28 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 27th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1913, to Mch 23 1914, that I last saw h im alive on Mch 23 1914, and that death occurred on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Glandular
and Pulmonary
(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.

(Signed) W. H. Holden M. D.
3/27 1914 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Thomas Cem. DATE OF BURIAL: March 28 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7691
Registered No. 11

1. PLACE OF DEATH.
County of Custer
City of Mackay

Registration District No. 109
Primary Registration District No. 2187
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clement Badiola

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Spaniard

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dont know (Month) (Day) (Year)

7. AGE: about 30 yrs old ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Viscaya Spain.

10. NAME OF FATHER: Mr? Badiola

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. B. Gaulet
(Address) Mackay Ida

15. Filed 4/7 1914 F. P. Richards Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 3rd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1914, to March 3 1914 that I last saw h.. alive on March 3 1914 and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:
Acute meningitis following Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) Lobar pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. E. Mason M. D.
3/24 1914 (Address) Mackay Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay Idaho
DATE OF BURIAL: Mch 6 1914

20. UNDERTAKER: Friends
ADDRESS: Mackay Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 74 109
Primary Registration District No. 2064 2187
File No. 769
Registered No. 49

1. PLACE OF DEATH.
County of Custer
City of Challis (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mathew Hughes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: David Kramer, 1851 (Month) (Day) (Year)

7. AGE: 63 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): United States.

10. NAME OF FATHER: David Kramer

11. BIRTHPLACE OF FATHER (State or Country): David Kramer

12. MAIDEN NAME OF MOTHER: David Kramer

13. BIRTHPLACE OF MOTHER (State or Country): David Kramer

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Bradshaw
(Address) Clayton

15.
Filed 2/20 1914 F. P. Bierwirth
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 19 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1914, to Feb 19 1914
that I last saw h.im alive on Feb 19 1914
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) 3 yrs. ..... mos. ..... ds.
Contributory Heart Failure
(Secondary)
..... (Duration) ..... yrs. ..... mos. 1 ds.
(Signed) J. W. Kelley M. D.
Feb 19 1914 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 ds. In the State 34 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? David Kramer
Former or usual residence Clayton Ida.

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho
DATE OF BURIAL: 2/22 1914

20. UNDERTAKER: J. R. Roberts
ADDRESS: Challis Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 1769
Registered No. 46

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant of John Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	—

6. DATE OF BIRTH
Mar. (Month) 18 (Day) 1914 (Year)

7. AGE
— yrs. — mos. — ds.
IF LESS than 1 day how many ..../.... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Coeur D'Alene

10. NAME OF FATHER John Bell

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Ivanne Mayer

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Mayer
(Address) 1209 5th Coeur D'Alene

15.
Filed 3-20 191 4 M P Bohnet Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature child five months. Stillborn.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bentley M. D.
Mar 19 1914 (Address) Coeur D'alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Mar 19 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 7695
Registered No. 45
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Flink

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Nov (Month) 13 (Day) 1832 (Year)

7. AGE
81 yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed. (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Olivr Flink

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Perry A Ban
(Address)

15. Filed 3-12 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8th 1914, to March 11th 1914
that I last saw him alive on March 10th 1914
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory Senility
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jno Busby M. D.
Mar 11 1914 (Address) Coeur D'alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mount Carroll Ill. DATE OF BURIAL 1914

20. UNDERTAKER: Gus Nelson ADDRESS: Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 7607
Registered No. 44

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James E Whitaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1876 (Year)

7. AGE
37 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work Lumber
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Walter

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Blanch Lewis

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S Whitaker
(Address) C D A

15. Filed 3-9 1914 M A Maynard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 7th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1914, to March 7th 1914, that I last saw him alive on March 7th 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the lungs

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunby M. D.
Mar 8 1914 (Address) Coeur D'alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	March 10 1914
20. UNDERTAKER S J Lewis	ADDRESS C D A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1010

File No. 769

Registered No. 43.

County of Kootenai

City of Ewa (No. Improved Highway St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W P Sanborn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Comm't Alsn

10. NAME OF FATHER: W P Sanborn

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Ellen Woodcock

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W P Sanborn

(Address) Ewa

15. Filed 3-9. 1914 Mark Dalbert Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 8 1914, to Mar 9 1914, that I last saw h Er alive on Mar. 8 1914, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

I dont Know

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Pretracted Delivery, breech Presentation

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Wood M. D.

Mar 9. 1914 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kootenai Co.

DATE OF BURIAL: Mar 9 1914

20. UNDERTAKER: J J Lewis

ADDRESS: Ewa

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-13-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. ____

Primary Registration District No. 1085

File No. 7698

County of Twin Falls

City of " "

(No. ____, ____ St.)

Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Sheldon Calmitis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 16 (Day) 97 (Year)

7. AGE: 17 Yrs. 7 Mos. 13 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch work
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Sheldon Iowa

10. NAME OF FATHER: Horatio S. Calmitis

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Selecta A Berry

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. M. Gates
(Address) ____

15.
Filed 4-30 1914
John J Coughlan
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h__ alive on ____ 191__, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Coroner's Jury Verdict Due to gun shot wound inflicted by his own hand.

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) Chas J. Crosby M. D.

19____ (Address) Twin Falls Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Sheldon Iowa — DATE OF BURIAL ____ 191__

20. UNDERTAKER: Chas J Crosby — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 7085
File No. 769

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louise Elizabeth Noble

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov (Month) 20 (Day) 1833 (Year)

7. AGE: 80 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Augustus Hubbell

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Mary F. Newell

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Geo. L. Noble
(Address): Kimberly Ida.

15.
Filed 4-5 1914
John F. Cowles
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24958

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1914, to April 5 1914, that I last saw her alive on April 4 1914, and that death occured on the date stated above, at 1 a.m. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
.....
.....
(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Worden M. D.
April 5 1914 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: West Union Ida.
DATE OF BURIAL: 1914

20. UNDERTAKER: Chas J Crosby
ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of .....

(No. ..... St.)

Registration District No. 37

Primary Registration District No. 1085

File No. 7700

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Samuel Weighall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	

6. DATE OF BIRTH. Feb (Month) 15 (Day) 1913 (Year)

7. AGE 1 Yrs. 1 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER J. S. Weighall

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Malvina Albertson

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Malvina Weighall

(Address) Contact Idaho

15. Filed Apr 7 1914 Johnnie Coghlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1914, to April 5 1914, that I last saw h~~im~~ alive on April 5 1914, and that death occured on the date stated above, at 5:10 P M.

The CAUSE OF DEATH* was as follows:

Rachitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Morgan M. D.

April 6 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hyrum Utah	191

20. UNDERTAKER	ADDRESS
Chas J. Crosby	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 7711

1. PLACE OF DEATH.
County of Twin Falls
City of ..
(No. ....., ... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah D. Yager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	Married

6. DATE OF BIRTH
April (Month) 15 (Day) 1860 (Year)

7. AGE
53 yrs. 0 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... House wife.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Harrison H. Parker

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Ella Beckwith

13. BIRTHPLACE OF MOTHER (State or Country) Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G A Yager
(Address) Twin Falls

15.
Filed Apr. 8 1914 John S Congleton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1914, to Apl. 8 1914, that I last saw h[illegible] alive on March 11 1914, and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of pancreas

(Duration) 1 yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) H W Wilson M. D.
Nov 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida — DATE OF BURIAL April 8 1914

20. UNDERTAKER T. J. Grossman — ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)
File No. 411
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No Name Lillibridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: Still Born ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Twin Falls.

10. NAME OF FATHER Earl Lillibridge

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Elsie Clara Morgenstern

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. C. P. Morgenstern
(Address) Churchill Idaho

15. Filed 4-11 1914 John D. Creighton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1914, to April 9 1914, that I last saw h-- alive on April 9 1914, and that death occured on the date stated above, at 7 am M.

The CAUSE OF DEATH* was as follows:
Premature birth
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H Worden M. D.
4/11 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	4-10 1914

20. UNDERTAKER	ADDRESS
O. J. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7711

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Clara Gilbridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH. May (Month) ... (Day) 1896 (Year)

7. AGE: 17 Yrs. 11 Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Chas. Morgenstern

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Lillie Grinsk

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Gilbridge

(Address) Buhl Idaho

15.

Filed 4-11 1914

John T. Eagleton
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 10th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1914, to April 10 1914, that I last saw h-er alive on April 10 1914, and that death occured on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH* was as follows:

Puerperal Hemorrhage
(6 mo's miscarriage)

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

(Duration ... yrs. ... mos. ... ds.

(Signed) H. W. Wilson M. D.

4.11.1914 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Apr 12 1914

20. UNDERTAKER: Chas J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of .....

Registration District No. 37

Primary Registration District No. 1085

(No. .... St.)

File No. 7711

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Breckenridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH. February (Month) 1 (Day) 1912 (Year)

7. AGE: 2 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls, Idaho

10. NAME OF FATHER L. L. Breckenridge

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Florence Holt

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. L. Breckenridge

(Address) Twin Falls Idaho

15. Filed 4-13 1914

John T. Eagleson
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1914, to April 12 1914, that I last saw h-r alive on April 11 1914, and that death occured on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH* was as follows:

Puerperal Hemorrhage

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) H. W. Wilson M. D.

4.14.1914 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 4-14 1914

20. UNDERTAKER: Chas. J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 741
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sadie M Sutherland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: April (Month) 27 (Day) 1879 (Year)

7. AGE: 34 yrs. 11 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: David D. Maxwell

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Alice T. Harris

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. C. Maxwell
(Address) Twin Falls Ida

15.
Filed 4-15 1914 John J. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1914, to April 14 1914, that I last saw her alive on April 14 1914, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Obstruction of the bowel

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. 10 ds.

(Signed) [illegible] M. D.
April 16 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: April 16 1914

20. UNDERTAKER: J. F. Goossen — ADDRESS: Twin Falls,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 7711
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlee Biggerman Cryderman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: April 9th 1842 (Month) (Day) (Year)

7. AGE: 71 yrs. ~~mos.~~ ~~ds.~~ IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmed mostly
(b) General nature of industry business, or dstablishment in which employed (or employer): Ret retired

9. BIRTHPLACE (~~State or~~ Country): Canada
10. NAME OF FATHER: Geo. Cryderman
11. BIRTHPLACE OF FATHER (State or Country): Canada.
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs T. H. Cook
(Address): Muskogee Okla.

15. Filed 5-1 191 4 John Cryderman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 23rd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11 1914, to Apr 23 1914, that I last saw h[illegible] alive on Apr 23 1914 and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:
Acute heart failure following pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. C. Lyon M. D.
19 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos..days. In the State ..yrs..mos..days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Solomon Kans
DATE OF BURIAL: 191

20. UNDERTAKER: T. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 7707
Registered No. ____

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Bittenbender

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH. March 27 (Month) (Day) 1856 (Year)

7. AGE: 58 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER John Bittenbender

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Mary Bitting

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. R. Bittenbender
(Address) Northwestern Gain

15.
Filed 5-1 1914
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 30 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1914, to April 30 1914, that I last saw him alive on April 30 1914, and that death occured on the date stated above, at 6-7 M.

The CAUSE OF DEATH* was as follows:

Pyaemia

(Duration) ____ Yrs. ____ mos. 30 ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) H. W. Carlon M. D.
May 1914 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Jonesboro
DATE OF BURIAL: ____ 1914

20. UNDERTAKER: [illegible]
ADDRESS: [illegible]

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085.
File No. 7711.
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Birdie Ford
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH: May 15 - 1879
(Month) (Day) (Year)

7. AGE: 34 yrs. 9 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Jas. K. Roden

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Mary Williams

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W N Ford
(Address) Twin Falls Ida

15. Filed 2-23 1914 John [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 21 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1914, to Feb 21 1914, that I last saw h[illegible] alive on Feb 21 1914 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. 5 ds.

(Signed) [illegible] M. D.
Feb 23 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Feb 23 1914

20. UNDERTAKER: D J Crowley
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 7709
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Thompson McMasters

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Unknown

6. DATE OF BIRTH. about ..... (Month) ..... (Day) 74 (Year)

7. AGE: about 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Coroner's Jury
(Address) .....

15. Filed 4-14 1914 John W. Coughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
about April 1st 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Coroner's Verdict
Accidentally falling from the Twin Rock into Snake River & Injuring near the Toll Gate at top of Perrine Grade Twin Falls Co.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M.D.
19... (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	4/19 1914
20. UNDERTAKER Chas J Crosby	ADDRESS Twin Falls

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 2085

File No. 371

Registered No. .....

County of .....

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellis Delores Rife

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 11 (Month) (Day) 1913 (Year)

7. AGE ..... Yrs. 9 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls County

10. NAME OF FATHER C.A. Rife

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Emma Lohman

13. BIRTHPLACE OF MOTHER (State or Country) Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C A Rife

(Address) Twin Falls

15.

Filed 4-10 191 4

John H Coughlen
Local Registrar

BYNS - YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 9 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1914, to Apr. 9 1914, that I last saw her alive on Apr 9 1914, and that death occured on the date stated above, at 5 50 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary) measles

(Duration ..... yrs. ..... mos. 7 ds.

(Signed) W. H. Cole M. D.

4/10/1914 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 4/10 1914

20. UNDERTAKER: Chas J Crosby — ADDRESS: T. Falls

MARGIN RESERVED FOR BINDING

...TE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
...tem of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
...uld state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7711

Name Dellis Deloris Rife

Date of Death 4-9-14

Cause of Death Broncho Pneumonia

Contributary Cause of death Marasmus

(Sign here) W. E. Pike M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2085
File No. 7712
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Klaas

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March 9th 1914 (Month) (Day) (Year)

7. AGE: 9 Yrs. 1 Mo. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... School girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER Fred J. Klaas

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Pfeifer

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. F. Klaas
(Address) Rout #2 Filer Idaho

15. Filed 4-24 1914
Edward Coughlin
Local Registrar

STAR - YORK CO., PTG. & BKBG. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no physician in attendance was practicing for however 1914, 4 23 1914, that I last saw h alive on 1914, and that death occured on the date stated above, at 8 45 M.

The CAUSE OF DEATH* was as follows: Pneumonia Broncho

(Duration) ..... Yrs. ..... mos. 3 or 4 ds.

Contributory (Secondary) measles

(Duration ..... yrs. ..... mos. 3 or 4 ds.

(Signed) C. J. Crosby M. D.

4/24/1914 (Address) Twin Falls Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 4-25 1914

20. UNDERTAKER: C J Crosby
ADDRESS: Twin Falls

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7712

Name Julia Klaas

Date of Death 4-23-14

Cause of Death Broncho Pneumonia

Contributary Cause of death [illegible]

(Sign here) W. H. Pike M.D.

FORM V. S. No. 5-25 M.? 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 111
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls,
City of Kimberly,
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert O. Vallins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 9 (Day) 1913 (Year)

7. AGE ..... Yrs. 7 Mos. 1? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Colorado Springs, Colo.

10. NAME OF FATHER John Vallins

11. BIRTHPLACE OF FATHER (State or Country) Sweden Europe

12. MAIDEN NAME OF MOTHER Rhobie L. Calkins

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Vallins
(Address) Hansen Idaho

15. Filed 4-27 1914 John W. Brighton Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 25 1914, to Apr 26 1914, that I last saw h.. alive on Apr 26 1914, and that death occured on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.
4/27 1914 (Address) Kimberly, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: Apr 27 1914

20. UNDERTAKER: J. F. Thoreson ADDRESS: Twin Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Hansen
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 2085
(No. , St.)

File No. 7714
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard E. Calkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Sept (Month) 13 (Day) 1835 (Year)

7. AGE: 78 yrs. 7 mos. 15 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Hiram Calkins

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Roby King

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Calkins
(Address) Hansen Idaho

15.
Filed 4-28 1914
John A. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1913, to April 24 1914, that I last saw h. in alive on Dec. 20 1913, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis following
Hypertrophy of Prostate
(Duration) 2 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. W. Olson M. D.
April 28 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: April 29 1914
20. UNDERTAKER: J. P. Grossman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 775
Registered No. 95

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410 Fifth St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver H. Snodgrass
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan. (Month) 12 (Day) 1883 (Year)

7. AGE: 31 Yrs. 3 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Jacob A. Snodgrass

11. BIRTHPLACE OF FATHER (State or Country): Ala.

12. MAIDEN NAME OF MOTHER: Daisy Miller

13. BIRTHPLACE OF MOTHER (State or Country): Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Amy Snodgrass
(Address) Mountain Home Idaho

15.
Filed 4-30 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1914, to April 30 1914, that I last saw him alive on April 29 1914, and that death occured on the date stated above, at 1A M.

The CAUSE OF DEATH* was as follows:
Accidental
Pinched on abdomen
by horse
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Fred A. Estabrook M. D.
4/30 1914 (Address) Salt Lake City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? [illegible]
Former or usual residence [illegible]

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida.
DATE OF [illegible] 1914

20. UNDERTAKER: Adolph Schreiber
ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

7716

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 771

Registered No. 94

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1504 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abraham Friedline

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 8 (Day) 1848 (Year)

7. AGE: 65 Yrs. 11 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Johnstown, Penn

10. NAME OF FATHER: Aaron Friedline

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Mrs Pyle

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. P. Friedline

(Address) Boise

15.

Filed 4 - 30 1914

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 27th 1914, to Apr. 29 1914, that I last saw him alive on April 29 1914, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. R. Numbers M. D.

Apr. 29 1914 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 1 1914

20. UNDERTAKER: Schrieber & Eidemiller — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics.

Registration District No. 2
Primary Registration District No. 1004
File No. 76

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1811 Wash St.)
Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarance Eugene Heckman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Feb (Day) 5 (Year) 1849

7. AGE: 65 Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired R R
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James I Heckman

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia

12. MAIDEN NAME OF MOTHER: Minnie Sargeant

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ursle E Heckman
(Address) 1811 Wash St

15.
Filed 4-1 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1913, to Mar 31 1914, that I last saw him alive on Mar 31 1914 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Paralyses

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H B Smith M. D.

1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 2 1914

20. UNDERTAKER: Jory & Simmons — ADDRESS: Boise Ida

BYNS - YORK BD., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 77771
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 2622 Madison St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Aberbillig
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 31st (Day) 1914 (Year)

7. AGE: — yrs. — mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: J. J. Aberbillig

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Edith L. Kelley

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J J Aberbillig
(Address) Boise Id.

15. Filed 4-2 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 1st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/31 1914 to 4/1 1914
that I last saw her alive on 4/1 1914
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Toxemia Eclampsia
Uremia ex nephritis
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Fred A Fitzsimmons M. D.
4/2 1914 (Address) Gault Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/2 1914

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise, Idaho,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Pittsburg

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

County of Ada — Primary Registration District No. 1004

File No. 79 7719

City of Boise (No. 110, East Bannock St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Andrews

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: About 40 Years ... yrs. ... mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not obtainable

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Schreiber
(Address) Boise Idaho

15.
Filed 4-3 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Dec 1913, to ... 191..., ~~that I last saw him~~ and last alive on April 1 1914 and that death occurred on the date stated above, at 1.15 P.M.

The CAUSE OF DEATH* was as follows: Gunshot Poison Suicide to the Jury, Verdict of Coroners Jury Finish held April 2nd 1914

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Adolph Schreiber, M.D. Coroner

19... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days. St Lukes Hospital 3 hours
Where was disease contracted if not at place of death?
Former or usual residence: Green River U. S. A.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery, County Plat — DATE OF BURIAL: April 3 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exac ment of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 80 772

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 527, So 13th St.)

2. FULL NAME Flora May Leidy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 3rd (Day) 1914 (Year)

7. AGE: ___ yrs. ___ mos. ___ ds.

IF LESS than 1 day how many 3 hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Thos Leidy

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Emma Steran

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Leidy.
(Address) Boise Idaho

15. Filed 4-3 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/3 1914 to 4/3 1914
that I last saw her alive on 4/3 1914
and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (Secondary)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Fred A Bellenger M. D.

4/3 1914 (Address) Jack

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 4/3 1914

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 81772

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1103 Ellis Ave St.)

2. FULL NAME Butler Hopewell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 8 (Day) 1867 (Year)

7. AGE: 47 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Saw Filer,

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER B C Hopewell

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Caroline Hupp

13. BIRTHPLACE OF MOTHER (State or Country) Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L E Hopewell

(Address) 1103 Ellis St.

15. Filed 4 – 6 1914 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4 1914, to Apr 4 1914, that I last saw him alive on Apr 4 1914, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows: Valvular Heart disease

(Duration) # Yrs. 1 mos. # ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. L. Grace M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Tetonia Ida — DATE OF BURIAL: Apr 2 1914

20. UNDERTAKER: Terry Summers — ADDRESS: Boise Ida

SYMS - YORK BD., PTRS. & SONS. 24859

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 82

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH.

County of Ada

City of Boise

(No. 924, Franklin St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Andress Regan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Widowed (~~Widow or Widower~~)

6. DATE OF BIRTH: January 29th (Month) (Day) 1847 (Year)

7. AGE: 77 yrs. 2 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nottinghamshire England

10. NAME OF FATHER: John Andress

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Carleton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Morgan A Regan
(Address) Boise Idaho

15. Filed 4-10 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1913, to June 8 1914 that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Callaway M. D.

19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: April 11 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise (No. Near, Elg Front St.)

File No. 93 772

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ah See

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) 1857 (Day) (Year)

7. AGE: 57 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chicken

(Address)

15. Filed 4-11 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead ~~10~~ to ~~am~~ April 11 1914 ~~that I last saw him alive on~~ ~~10~~, and that death occurred on the date stated above, at 12 30 ~~M~~ P M.

The CAUSE OF DEATH* was as follows:

Syphilis and Locomotor Ataxia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber ~~M. D.~~

19 (Address) Boise Corner Ada Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery Boise Ida	April 11 1914
20. UNDERTAKER	**ADDRESS**
Schreiber & Sidenfaden	Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 84
Registered No. 1721

1. PLACE OF DEATH.
County of Ada
City of Boise, Idaho.
(No. 506 Pueblo St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ross Wallis French

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. 16th (Month) (Day) 1914 (Year)

7. AGE: ..... Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot, Idaho

10. NAME OF FATHER: Chas Lee French

11. BIRTHPLACE OF FATHER (State or Country): Montpelier, Idaho,

12. MAIDEN NAME OF MOTHER: Vida Hyde

13. BIRTHPLACE OF MOTHER (State or Country): Ogden, Utah,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas French
(Address) 506 Pueblo

15.
Filed 4-13 1914
W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 8th, 1914, to Apr 13th 1914, that I last saw him alive on Apr 13th 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Contintis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. E. Smith M. D.
Apr 13. 1914. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence 506 Pueblo St

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/14 1914

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise, Idaho

Dr. Smith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 85
Registered No. 125

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 1006 E. Wash St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Clark Wallace
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH. Oct (Month) 19 (Day) 1846 (Year)
7. AGE: 67 Yrs. 5 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Shoe Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) New Hampshire.
10. NAME OF FATHER Ephram Wallace
11. BIRTHPLACE OF FATHER (State or Country) Massachusetts
12. MAIDEN NAME OF MOTHER Sarah Clark
13. BIRTHPLACE OF MOTHER (State or Country) Massachusetts
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry H. Runyon
(Address) 1006 E Washington St
15. Filed 4 — 19 1914 M. L. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 15 1914, to ..... 191..., that I last saw him alive on April 15 1914, and that death occured on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Chronic mitral insufficiency complicated by Arterio Sclerosis
at least (Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H. M. Robertson M. D.
4/17 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Naperville Ill — DATE OF BURIAL: Apr 22 1914
20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Ida

BYRNE - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2010
Primary Registration District No. 1010
File No. 7926
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant not named

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Mar (Month) 25 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: L. R. Latimer

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Loretta Bills

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. R. Latimer
(Address) Emmett Ida.

15.
Filed 4-3- 1914 J. V. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 27th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 1914, to Mar 27 1914 that I last saw h[illegible] alive on Mar 26 1914 and that death occurred on the date stated above, at 8 a. M

The CAUSE OF DEATH* was as follows:
Inanation
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds
Contributory (Secondary) Premature
..... (Duration) ..... yrs. ..... mos. ..... ds
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds
In the State..... yrs..... mos..... ds
Where was Disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: Mar 27 1914

20. UNDERTAKER: C. D. Beckenum
ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7427
Registered No. 1 line

1. PLACE OF DEATH.
County of Washington
City of Weiser
Registration District No. 87
Primary Registration District No. 2454
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William McMillan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: October (Month) 15 (Day) 1845 (Year)

7. AGE: 69 yrs. 5 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Land
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): British Columbia

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) T. J. Burnside Weiser, Idaho

15. Filed March 27 1914 Houston E. Snyder Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1914, to March 26 1914 that I last saw h— alive on March 26 1914 and that death occurred on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:
General debility following amputation

..... (Duration) — yrs. — mos. 6 ds.
Contributory (Secondary) Senility
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Houston E. Snyder M. D.
March 27 1914 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Midvale — DATE OF BURIAL: Mar. 27th 1914

20. UNDERTAKER: [signature] — ADDRESS: Midvale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. — Registration District No. 87

County of Washington — Primary Registration District No. 2154

City or Midvale (No. ....., ... St.)

File No. 7728

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Emma Widmer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 6 (Day) 1881 (Year)

7. AGE: 32 yrs. 5 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Michaels

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mat Lucas

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Orch Widmer
(Address) Midvale

15. Filed March 18 1914 — Houston E. Snyder, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17. 1914, to Mar 17 1914
that I last saw h er alive on March 17 1914
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Embolism of Heart
following childbirth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) W. H. Marshall M. D.
Mar 17 1914 (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale, Idaho — DATE OF BURIAL: Mar 18 1914

20. UNDERTAKER: [signature] — ADDRESS: Midvale

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

CERTIFICATE OF DEATH

Registration District No. 59

County of Blaine — Primary Registration District No. 2139 — File No.

City of Arco (No. ....., ... St.) — Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Perschall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1830 (Year)

7. AGE: 83 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Perschall

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Lydia Logdson

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. Hohn
(Address) Arco Idaho

15. Filed 3/19 1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/14 1914, to 2-17 1914 that I last saw h[illegible] alive on 2/17 1914 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) Cardiac insufficiency

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) [illegible] M. D.

2/17 1914 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho — DATE OF BURIAL: 3-19 1914

20. UNDERTAKER: Louis Hohn — ADDRESS: Arco, Idaho

N. B.—Every item of information should be stated EXACTLY. Particular attention is called to the fact that it may be properly classified. Exact statement of OCCUPATIONS should be made. Refer to back of certificate.

WRITE IN BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7731

Registered No. 17

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

2. FULL NAME Bessie Mabel Mann

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 8 (Day) 1903 (Year)

7. AGE: 10 yrs. 6 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Jefferson County, Iowa

10. NAME OF FATHER: George P. Mann

11. BIRTHPLACE OF FATHER (State or Country): Jefferson Co. Iowa

12. MAIDEN NAME OF MOTHER: Pearl E Hill

13. BIRTHPLACE OF MOTHER (State or Country): Hedrick, Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George P. Mann
(Address) Caldwell Idaho

15. Filed April 1st 1914 John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1914, to March 31 1914, that I last saw h[illegible] alive on March 31 1914, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

..... (Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Miller M. D.

4-1-1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Brighton Iowa.

DATE OF BURIAL: 4/1 1914

20. UNDERTAKER: W. C. Dye

ADDRESS: Caldwell

SYMS - YORK CO., PTRS. & BDRS. 19760

Dr Miller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH 3

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7732
Registered No. 18

1. PLACE OF DEATH.
Registration District No. .....
Primary Registration District No. 2005
County of Canyon
City of Caldwell Rural (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucinda Daly.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 6 (Day) 1862 (Year)

7. AGE: 51 yrs. 9 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: P. U. Neely

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Betsy Ann Pigg

13. BIRTHPLACE OF MOTHER (State or Country): Indiana,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Daly
(Address) Caldwell Idaho

15.
Filed April 6 1914 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1900, to April 3 1914
that I last saw her alive on March 3 1914
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Valvular disease of heart
or by exhaustion following
asthma & dropsy. Existed for 4 yrs.
(Duration) 4 yrs. ..... mos. ..... ds.
Contributory Asthma
(Secondary)
4 (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Lee M. D.
4/6 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 4-6 1914

20. UNDERTAKER: W. C. Dye
ADDRESS: Caldwell Idaho.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2051
File No. 7747
Registered No. 374

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Linus M. Drake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH
May (Month) 8. (Day) 1861 (Year)

7. AGE
52 yrs. 8 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Cabinet maker
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Riley Victor Drake

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Elizabeth M. Drake
(Address) Rathdrum, Ida.

15.
Filed 1/10 1914
L. L. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 29th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 10. 1914, to Jany 29. 1914, that I last saw him alive on Jany 24. 1914, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Cirrhosis liver

about (Duration) 2 yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Penny M. D.
1/30. 1914 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum	1/31 1914
20. UNDERTAKER	ADDRESS
Beck	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. ~~2118~~ 12

County of Kootenai Primary Registration District No. 2118

City of Hoosier-Miami (No. ....., ... St.)

File No. 7748

Registered No. 373

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Allison

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: About (Month) ..... (Day) 1878 (Year)

7. AGE: 36 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Jackson Co. N. C.

10. NAME OF FATHER: Hannibal Heaton

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Zachary

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George L. Heaton
(Address) 218 S. Fisher, Roseburg

15. 4/10 D D Brennan

Filed Jan 27 1914 Wm. J. Lander Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.... that I last saw h..... alive on ..... 191.... and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) None M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Sunset Cemetery — DATE OF BURIAL: Jan. 25 1914

20. UNDERTAKER — ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12

Primary Registration District No. 207

(No. ....., ... St.)

File No. 7749

Registered No. 372

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abraham Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	widower

6. DATE OF BIRTH: March 7. 1848 (Month) (Day) (Year)

7. AGE: 65 yrs. 10 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Eisenhauer
(Address) Post Falls. R. F. D.

15. Filed Jan. 8 1914 J. D. Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 8th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1. 1914 to Jany 8. 1914, that I last saw h[illegible] alive on Jany 8. 1914 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Chronic enlargement Liver

(Duration) about 15 yrs. ..... mos. ..... ds.

(Signed) Frank Wenz M. D.

1/9. 1914 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane. DATE OF BURIAL: 1/10 1914

20. UNDERTAKER: Buchannan. ADDRESS: Spokane.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2051
(No. ....., ... St.)

File No. 7750
Registered No. 371
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elisha T. Berry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	married

6. DATE OF BIRTH: July 5th 1835 (Month) (Day) (Year)

7. AGE: 78 yrs. 5 mos. 28 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Vermont.

10. NAME OF FATHER Elisha Berry

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles A. Berry
(Address) Coeur d' Alene.

15. Filed 4/10 1914 S S Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 2nd 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1913, to Jany 1. 1914, that I last saw h im alive on Jany 1st 1914 and that death occurred on the date stated above, at 6.9 M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 1 yrs. 3 mos. ds.

Contributory (Secondary) Cancer of face

(Duration) 2 yrs. mos. ds.

(Signed) Frank Wing, M. D.
1/3 1914. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kleph | DATE OF BURIAL: 1/4 1914

20. UNDERTAKER: Rathdrum | ADDRESS: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12

Primary Registration District No. 2051

(No. ....., ... St.)

File No. 7751

Registered No. 404

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hatch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: March (Month) 23. (Day) 1914. (Year)

7. AGE: ..... yrs. less than mos. 1 ds.

IF LESS than 1 day how many ..8.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rathdrum Ida.

10. NAME OF FATHER George F. Hatch

11. BIRTHPLACE OF FATHER (State or Country) Col.

12. MAIDEN NAME OF MOTHER Mary Nickey

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. F. Hatch
(Address) Rathdrum, Ida.

15. Filed 4/10 1914 J. D. Thurman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 24. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth, March 23. 191X, to March 24. 191X, that I last saw him alive on March 23. 1914, and that death occurred on the date stated above, at 4. 4 M.

The CAUSE OF DEATH* was as follows:
Failure of closure of foramen ovale - was a blue baby

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wing M. D.
3/24 1914 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum	3/25 1914

20. UNDERTAKER	ADDRESS
Nunn	

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County of Kootnai

City or Town of

Registration Dist. No.

[If death occurred outside USUAL RESIDENCE give facts asked for under "Special Information"]

Idaho ~~WASHINGTON~~ STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 7752

File No.

Registered No. 402

(No. , St.; Ward)

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

RECEIVED MAR 6 1914

Full Name Leland Edwin Sly

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

Referred to

6 DATE OF BIRTH: March 21, 1880 (Month) (Day) (Year)

7 AGE: 33 yrs. 11 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Wisconsin

PARENTS

10 NAME OF FATHER: Joseph Sly

11 BIRTHPLACE OF FATHER (State or country): Canada, ~~Pennsylvania~~

12 MAIDEN NAME OF MOTHER: Elizabeth Roberts

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur M Bushnell

(Address) Tekoa Wash.

15 Filed 4/10, 1914 DD Brennan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. 25, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 191..., to ..., 191..., that I last saw h... alive on ..., 191..., and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH * was as follows:

Sudden death, probably due to heart failure,

(Duration) ... yrs. ... mos. ... ds.

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto N. Rosenkrans, M. D.

March. 2 1914 (Address) Latah, Wash.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Latah, Wash. DATE OF BURIAL: Feb. 27 1914

20 UNDERTAKER ADDRESS

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12

County of Fremont Primary Registration District No. 2118

City of Desmet (No. ....., ... St.)

File No. 7753

Registered No. 401

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julian Gregory

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1911 (Year)

7. AGE: ..... yrs. 3 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Desmet, Ida

10. NAME OF FATHER: Sam Gregory

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Christina

13. BIRTHPLACE OF MOTHER (State or Country): Desmet, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Gregory
(Address) Desmet, Ida

15. Filed Feb 17 1914 — 4/10 — D D Demmons — Wm J Kinder Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Supposed to be suffocation
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....
DATE OF BURIAL: Feb. 17 1914

20. UNDERTAKER: None
ADDRESS: .....

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: *(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

N
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Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7754
Registered No. 402

1. PLACE OF DEATH.
County of Latah
City of Deary

Registration District No. 17
Primary Registration District No. 2118
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Zachari

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
— (Month) — (Day) 1917 (Year)

7. AGE
— yrs. 26 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) Rond

9. BIRTHPLACE (State or Country): Dranet, Ida

10. NAME OF FATHER: Jack Zachari

11. BIRTHPLACE OF FATHER (State or Country): Dranet, Ida

12. MAIDEN NAME OF MOTHER: Mary

13. BIRTHPLACE OF MOTHER (State or Country): Dranet Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sinsta Nistachen
(Address) Dranet, Ida

15.
Filed 4/14 1914 D. A. Freeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb 11 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1914, to Feb 11 1914
that I last saw him alive on Feb 8 1914
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis

..... (Duration) ..... yrs. 3 mos. — ds.
Contributory (Secondary) Neglect
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Leonard M. D.
Feb 13 1914 (Address) Dranet, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Deary
DATE OF BURIAL: 2 Jan 1914

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7757
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs Anna Gjold

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Jan. (Month) 9 (Day) 1914 (Year)

7. AGE: 75 yrs. 5 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Per Jacobson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Hjortsman
(Address) Troy Idaho

15.
Filed Jan 14 1913
C. V. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1913, to Jan 9 1914
that I last saw her alive on Jan 3 1914
and that death occurred on the date stated above, at 1 9 M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Arterio-sclerosis

(Duration) over 2 yrs. ..... mos. ..... ds.
Contributory (Secondary) Uraemia
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. V. Olson M. D.
Jan 9 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bear Creek Cemetery
DATE OF BURIAL: Jan 11 1914

20. UNDERTAKER: John Calen
ADDRESS: Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

File No. 7958

County of Bois

Primary Registration District No.

Registered No.

City of Mc-Call

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alli Maria Kangas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH

May (Month) 7 (Day) 1912 (Year)

7. AGE

1 yrs. 10 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mc. Call Ida

10. NAME OF FATHER John Kangas

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER Elizabeth Koski

13. BIRTHPLACE OF MOTHER (State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Son Eld

(Address) Roseburg

15.

Filed ..... 191 .....

D. W. Compton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 M. Feb. 20 1914, to 8:30 P.M. Feb. 20 1914, that I last saw h[illegible] alive on Feb. 20 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. W. Compton M. D.

2/21 1914 (Address) Roseburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fir Cemetery Mc Call — DATE OF BURIAL: 2/23 1914

20. UNDERTAKER: Family — ADDRESS: Mc Call

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy", "Collapse," "Coma," "Convulsions," "Debility, ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 15
Primary Registration District No. 24
File No. 7759
Registered No.

1. PLACE OF DEATH.
County of Boise
City of McCall
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Heikkola

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July 14 Th (Month) (Day) 1893 (Year)

7. AGE: 20 yrs. 7 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Particular Kind Work
(b) General nature of industry business, or establishment in which employed (or employer): Housewife (RDW)

9. BIRTHPLACE (State or Country): Co. Lincoln Red Cannoy, St Wyo

10. NAME OF FATHER: Chas Koski

11. BIRTHPLACE OF FATHER (State or Country): Finland, State Kaunn

12. MAIDEN NAME OF MOTHER: Lizzi Koski

13. BIRTHPLACE OF MOTHER (State or Country): Finland, State Wisharma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. H. Heikkola
(Address) McCall

15. Filed Feb 6th 1914 R. W. Whiteman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Febuary 1 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 29 1914, to Jan 30 1914, that I last saw her alive on Jan 30 1914, and that death occurred on the date stated above, at 3:10 P. M.

The CAUSE OF DEATH* was as follows: (Statement of Relatives)
Puerperal Septicemia
(Baby & Mother been confined by a midwife on Jan. 18 1914)
(Duration) yrs. mos. 11 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. W. Whiteman M. D.
19 (Address) New Meadows Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCall Ida. | DATE OF BURIAL 191

20. UNDERTAKER: None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gooding
City of Gooding (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1014
Primary Registration District No. 2014

File No. 7760
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Orville M. Darling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: May (Month) 5 (Day) 1850 (Year)

7. AGE: 63 yrs. 10 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Jacob Darling

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O.E. Darling
(Address) Gooding Ida.

15. Filed ..... 1914 ..... [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J.H. Cromwell Coroner
By ..... 19... (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida.
DATE OF BURIAL: 3/18 1914
UNDERTAKER'S ADDRESS: [illegible] Gooding

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-29-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 76

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Gooding

City of Gooding (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs Grace May adkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Feb. (Month) 6th (Day) 1892 (Year)

7. AGE: 21 yrs. 11 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Alva L Ruland

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Ruland

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E B Ruland
(Address) Gooding Ida

15. Filed Feb. 19. 1914 T. T. Cary M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3rd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1913, to Feb 3 1914 that I last saw her alive on Feb. 3 1914, and that death occurred on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Cromwell M. D.
2/19 1914 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetery
DATE OF BURIAL: 2/5 1914

20. UNDERTAKER: A E Thompson
ADDRESS: Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
ment of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7765

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of

City of

(No. , St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Mary Heilner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: September 21 - 1886 (Month) (Day) (Year)

7. AGE: 27 yrs. 6 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Co. North Carolina

10. NAME OF FATHER: Henry Potts

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Jane Evitt

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Heilner
(Address) Nampa Ida

15.
Filed Mch 16 1914 D. D. Colaneri
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 16 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1913, to Mch 16 1914 that I last saw her alive on Mch 16 1914, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Specific Meningitis
Symptoms & Bacillus
Influenzae &
Pneumonia
(Duration) 3 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. D. Colaneri M. D.
Mch 16 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohler Town — DATE OF BURIAL: Mch 19 1914

20. UNDERTAKER: D. B. Shelbaugh — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 14

County of Custer

Primary Registration District No. 2061

File No. 7766

City of Challis (No. ....., ... St.)

Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Zurwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Single (Write the word.)

6. DATE OF BIRTH

Not known 1
(Month) (Day) (Year)

7. AGE

30 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Rancher

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Ky.

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER

(State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER

(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed March 7th. 1914 R. Kistler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March between 2 & 5th. 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Self distruction by means of a rifle in his own hands.

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Ebberts Coroner M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Challis J. S. Ebberts — DATE OF BURIAL: 3/7 1914 191...

20. UNDERTAKER — ADDRESS: Challis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7767

Registered No. 67

1. PLACE OF DEATH.
County of Custer
City of Challis

Registration District No. 14
Primary Registration District No. 2061
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarrence E. Fuller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 23th. (Day) 1914 (Year)

7. AGE: 73 yrs. 5 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Caleb Fuller

11. BIRTHPLACE OF FATHER (State or Country): New H.

12. MAIDEN NAME OF MOTHER: Miriam Wood

13. BIRTHPLACE OF MOTHER (State or Country): Ver.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Fuller,
(Address) Chelsea Okla.

15.
Filed March 26 1914
C. L. Kirtley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 26 1914. 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10th 1914, to March 25th. 1914 191
that I last saw him alive on March 25, 1914 191
and that death occurred on the date stated above, at 8 M.
The CAUSE OF DEATH* was as follows:
Tumor of Spleen(probably carcenoma)

..... (Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Kirtley M. D.
3/26 1914 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Challis
DATE OF BURIAL: 3/27.14 191

20. UNDERTAKER: J. L. Ebberts
ADDRESS: Challis

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: *(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Mason

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9 7768

Registered No.

1. PLACE OF DEATH.
Registration District No. 127
Primary Registration District No. 1201
County of Shoshone
City of Kellogg (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Hannah Matetta

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	single

6. DATE OF BIRTH: Mar. (Month) 25 (Day) 191X (Year)

7. AGE: — yrs. — mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Tony Matetta

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Alva Vergobbi

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tony Matetta
(Address) Kellogg, Idaho

15. Filed 4/12/ 1914 Geo. S Fasbender Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 28th 1914, to May 30th 1914 that I last saw h[illegible] alive on Mar 30th 1914, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Liver trouble

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. 5 ds.

(Signed) J. A. Mason M. D.
Apl 11 1914 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenwood Cem. DATE OF BURIAL: Apr 2 1914

20. UNDERTAKER: Thornhill ADDRESS: Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Mason

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. Y 7769

Registered No.

1. PLACE OF DEATH. Registration District No. 123

County of Shoshone Primary Registration District No. 2201

City of Kellogg (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Scott

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	single

6. DATE OF BIRTH: April (Month) 9 (Day) 1914 (Year)

7. AGE: ___ yrs. ___ mos. ___ ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. D. Scott

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Mamie Bottger

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. F. Bottger

(Address) Wardner Idaho

15. Filed Apr. 13 1914 Geo. D. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191....
that I last saw h..... alive on ..... 191....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Still Born

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Mason M. D.

4/11 1914 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs... ..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenwood Cemetery DATE OF BURIAL: Apr 14 1914

20. UNDERTAKER: Thornhill ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7 7170
Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Paul Paulsen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Dane
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar. (Month) 18 (Day) 189[illegible] (Year)

7. AGE: 24 yrs. — mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cement Worker
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logstor Denmark

10. NAME OF FATHER: Jens Paulsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wax B Richardson
(Address) 2717-E 8th Ave. Spokane, Wash.

15.
Filed ..... 191...
Geo B Lasher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1914, to March 23, 1914, that I last saw h[illegible] alive on March 23, 1914, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Crushing injury to head — Mine accident
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo H Kennicott M. D.
March 24 1914 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ~~mos.~~ ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenwood Cemetery — DATE OF BURIAL: Mar. 25 1914

20. UNDERTAKER: E B Thornhill — ADDRESS: Kellogg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5—10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7771
Registered No.

1. PLACE OF DEATH. Registration District No. 123
County of Shoshone Primary Registration District No. 7201
City of Kellogg (No. , St.)
If death occurs away from usual residence, give residence. If not known, so state. If inmate of institution, write name of institution instead of street and number. If transient or stranger, so state. If death occurred in a hospital or institution or camp give its NAME instead of street and number.

2. FULL NAME Christine Penney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH: Feb (Month) 28 (Day) 1909 (Year)
7. AGE: 5 yrs. — mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: W. L. Penney
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Christine Lindquist
13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Penney
(Address) Wardner, Idaho
15.
Filed Mar 24 1914 Geo. D Graber Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 21 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 12 1914, to March 21, 1914 that I last saw h[illegible] alive on March 21 1914, and that death occurred on the date stated above, at 9.40 P. M.
The CAUSE OF DEATH* was as follows: Septicaemia - (Had endocarditis, tonsilitis, enteritis, meningitis - pleurisy)
(Duration) 2 yrs. mos. 14 ds.
Contributory (Secondary) La Grippe 2
(Duration) yrs. mos. ds.
(Signed) Geo. D. Kennett M. D.
March 23 1914 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenwood - Kellogg
DATE OF BURIAL: Mar. 25 1914
20. UNDERTAKER: E. B. Thornhill
ADDRESS: Kellogg Ida.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PRIME CAUSE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Bruneau
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 42
Primary Registration District No. 2121
(No. 1, St.)

File No. 7772
Registered No. 8
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Santiago Oppisi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Basque
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 1 (Month) (Day) 1862 (Year)

7. AGE: 52 yrs. — mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheepherder
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jac M Yrazabal
(Address) Bruneau

15. Filed March 17 1914 J C Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191..., that I last saw h ✓ alive on ✓ 191..., and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Bartlett M. D.
3/17 1914 (Address) Bruneau

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida
DATE OF BURIAL: 3/18 1914

20. UNDERTAKER: J. M. Cowan
ADDRESS: Mt. Home Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [redacted]

Registered No. 111

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St. Lukes Hosp. St.)

Registration District No. 7

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hastings.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) — 1 (Year)

7. AGE: 40 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheepherder.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. M. McCracken

(Address) Boise, Idaho

15. Filed Apl 25 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 23d 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20th 1914, to April 22nd 1914, that I last saw him alive on April 22nd 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis —

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary): bullet wound

(Duration) yrs. mos. ds.

(Signed) John Baurtz M. D.

April 25 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: Apr 25 1914

20. UNDERTAKER: Fry & Summers. ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 89
Registered No. 111

1. PLACE OF DEATH.
County of Ada.
City of Boise (No. 1 E Jefferson East St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Franklin Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. (Month) August (Day) 18 (Year) 1874
7. AGE: 40 Yrs. — Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: S. T. Baker
11. BIRTHPLACE OF FATHER (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: Not obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Josephine Baker
(Address) Boise, Idaho
15. Filed 4-26 1914 W. R. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Apr. (Day) 25 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 28 1914, to Apr. 25 1914, that I last saw him alive on Apr. 24 1914, and that death occured on the date stated above, at 5-30 P.M.
The CAUSE OF DEATH* was as follows:
Mitral Regurg. and
Acute Dilatation of Heart.
General Anasarca
(Duration) 4 Yrs. mos. ds.
Contributory (Secondary) Anasarca & Dilatation
(Duration yrs. 4 mos. ds.
(Signed) J. Carl Hill M. D.
4/26 1914 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho City — DATE OF BURIAL: Apr 27 1914
20. UNDERTAKER: Terry & Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 1715
Registered No. 91

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 419 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas S Spencer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 18th (Day) 1862 (Year)

7. AGE: 51 Yrs. 11 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Linley H Spencer

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Phoebe R Cooper

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W G Spencer
(Address) Lucky Dide

15. Filed 4-29 1914 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1914, to April 27 1914
that I last saw h— alive on 27 April 1914
and that death occured on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:

Haemmagic Purpura

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary): Spotted fever

(Duration) yrs. mos. 4 ds.

(Signed) R E Blunt M. D.
19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho — DATE OF BURIAL: 4/30 1914

20. UNDERTAKER: Schroeder & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 1116
Registered No. 92

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 112 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. H. French

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Unknown (Day) (Year) 1831

7. AGE: 83 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Inmate Ada County Farm
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Schneider
(Address) Boise

15.
Filed 4-29 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1913, to April 27 1914, that I last saw h— alive on April 26 1914, and that death occured on the date stated above, at 12 M.

The ~~CAUSE OF DEATH~~* was as follows:
Arteriosclerosis

(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Old age
(Duration yrs. mos. ds.
(Signed) P E Schmitz M. D.
19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Co Plot | DATE OF BURIAL: 4/30 1914

20. UNDERTAKER: Schneider & Hidenfadden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

7777

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1104

(No. 1403 Warm Springs Ave)

File No. 7777

Registered No. 93

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harrison Boylen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 9 (Day) 1840 (Year)

7. AGE: 73 Yrs. 5 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Boylen

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lydia Brown

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W G Boylen

(Address) 1403 Warm Springs Ave Boise

15.

Filed 4-29 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1913, to April 28 1914, that I last saw h[illegible] alive on April 28 1914 and that death occured on the date stated above, at 8 45 P.M.

THE CAUSE OF DEATH* was as follows: Acute Dilatation of Heart, Myocarditis.

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) 1 yrs mos. ds.

(Signed) W S Tyler M. D.

4-29 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 30 1914

20. UNDERTAKER: Terry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 17444
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of near Boise
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie Cummings

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 4 (Day) 1879 (Year)

7. AGE: 35 Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Jacob Gilmore

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. F. Cummings
(Address) Boise Idaho R.R. No1

15.
Filed 4-15 1914 W. S. Parker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913 to Apr 18 1914
that I last saw her alive on Feby 1914
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration — yrs. 4 mos. — ds.

(Signed) Jno. A. Stewart M. D.
19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Joplin Cemetary — DATE OF BURIAL: Apr 19 1914

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 1811

Registered No. .....

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Soldiers Home (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin F. Dwyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): W

6. DATE OF BIRTH. Not Obtainable (Month) (Day) 1829 (Year)

7. AGE 85 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Veteran Civil War

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Not Obtainable

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. G. Burnett

(Address) Soldiers Home

15.

Filed 4-22 1914

W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/21 1914, to 4/21 1914, that I last saw him alive on 4/21 1914 and that death occured on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Struck by accident. Struck by automobile

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Tyler M. D.

4/23 1914 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 23 1914

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTYS. & SUPS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Minidoka — Registration District No. 18

City of Heyburn — Primary Registration District No. 2102

(No. ....., ... St.)

File No. 7780

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarence C. Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Dec. (Month) 29 (Day) 1912 (Year)

7. AGE: 1 yrs. 4 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of business, or establishment in which employed: [illegible]

9. BIRTHPLACE (State or Country): Ogden Utah

10. NAME OF FATHER: C. Hansen

11. BIRTHPLACE OF FATHER (State or Country): [illegible]eber Co Utah

12. MAIDEN NAME OF MOTHER: [illegible]ley Burke

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible] Hansen
(Address) [illegible] burn

15. Filed May [illegible] 1914 — V. R. Kellum, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1914, to April 27 1914, that I last saw him alive on April 27 1914, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Intestinal perforation
Typhoid Fever

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) V. R. Kellum M. D.

19.... (Address) Heyburn.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Heyburn Ida	April 29 1914
20. UNDERTAKER	ADDRESS
L. D. Gallogly	Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19[illegible]

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4771

Registered No. 148

1. PLACE OF DEATH. Registration District No. 84

County of Lemhi Primary Registration District No. 2161

City of Decatur (No. Cor. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mattie E. Hunter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: December 1883
(Month) (Day) (Year)

7. AGE: 31 yrs. 5 mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mississippi

10. NAME OF FATHER: E. A. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry P. Hunter

(Address) MacKay Ida

15. Filed 4/2 1914 O. B. Lucier Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 2 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 20 1914, to April 2 1914 that I last saw her alive on Apr. 2 1914, and that death occurred on the date stated above, at 6.20 P. M.

The CAUSE OF DEATH* was as follows:

Septicaemia, following miscarriage

(Duration) yrs. 1 mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frances N. Poole M. D.

Apr. 2 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 13 ds. In the State 75 yrs. mos. ds.

Where was disease contracted, if not at place of death? Mackay, Idaho.

Former or usual residence Mackay, Idaho

19. PLACE OF BURIAL OR REMOVAL: Mackay, Idaho. DATE OF BURIAL: 4/7 1914

20. UNDERTAKER: The Mackay Undertaking Co ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4785

Registered No. 149

1. PLACE OF DEATH. Registration District No. 8

County of Bannock Primary Registration District No. 2

City of Pocatello (No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thos. Reagan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): Information to be had

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Reagan
(Address) Pocatello Ida

15. Filed April 2 1914 R B Tenney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1914, to April 1 1914, that I last saw him alive on April 1 1914, and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH*, was as follows:
Acute dilation of Heart
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Bronchial Abscess
(Duration) ..... yrs. ..... mos. 7 ds.
(Signed) A M Lewton M. D.
4/2 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. 7 ds.
Where was disease contracted? .....
If not at place of death? .....
Former or usual residence Can't know

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 4/4 1914

20. UNDERTAKER: The Nadeau Undertaking Co — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4778

Registered No. 150

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 628, N. Main St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161

2. FULL NAME Adie C. Williamson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH
(Month) (Day) (Year): 1877

7. AGE: 37 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: /

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed. Williamson
(Address) Pocatello Ida

15.
Filed 4/2 1914
O. B. Terry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1913, to Apr. 2 1914 that I last saw h[er] alive on Apr. 2 1914, and that death occurred on the date stated above, at 11.20 P. M.

The CAUSE OF DEATH* was as follows:
Post partum hemorrhage

(Duration) ..... yrs. ..... mos. 1/2 hr. ds.

Contributory (Secondary) Uraemia

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Frances M. Poole M. D.
Apr 4 1914 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary
DATE OF BURIAL: 4/5 1914

20. UNDERTAKER: The Tucker Und. Co
ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5—20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Power
City of Arbon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2461
(No. ....., ... St.)

File No. 7787
Registered No. 157
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milford C. Switty

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 1st 1869 (Month) (Day) (Year)

7. AGE: 44 yrs. 10 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Barton Switty

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Stugen

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Char Switty
(Address) Arbon Ida.

15. Filed 4—6—1914 O B Lacey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 4 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Nephritis - 2 years duration
Extensive edema

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O B Lacey M. D.
4-6-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Arbon Cem — DATE OF BURIAL: April 7 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: Pocatello Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 1775
Registered No. 152

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 725 East Bridger St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angeline Katsaros
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Jan 1 (Month) 11 (Day) 1914 (Year)

7. AGE: yrs. 3 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Bill Katsaros

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Ida Wilson

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Bill Katsaros
(Address): City

15.
Filed Apr 7 1914 W. O. B. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191..., that I last saw her ~~alive on~~ dead Apr. 6 1914 and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:
Probably pneumonia

(Duration) ~ yrs. ~ mos. 2 ds.
Contributory (Secondary): Lack of care
(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) W. J. Howard M. D.
4/6/1914 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem
DATE OF BURIAL: April 7 1914
20. UNDERTAKER: Caufield and Schumacher
ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 3
(No. 906, Do 2nd Ave, St.)

File No. 4
Registered No. 153
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Cesenia ~~Taylor~~ Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widow

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1843 (Year)

7. AGE: 70 yrs. 4 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: James N. Jones

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Jones

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) 906 Do 2nd Ave
(Address) Myrtle Lassetter

15.
Filed 4/6 1914 O B Leeper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913, to April 6th 1914
that I last saw her alive on April 6th 1914,
and that death occurred on the date stated above, at 10:15 a M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus

(Duration) 3 yrs. 2 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O B Leeper M. D.
4-7- 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 4/8 1914

20. UNDERTAKER: The Walker Mtd Co — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 17904
Registered No. 154

1. PLACE OF DEATH.
County of Bannock,
City of Pocatello Idaho, (No. County farm St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed May 7, 1914 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1914, to April 29 1914, that I last saw h[illegible] alive on April 29 1914, and that death occured on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis.
(Duration) unknown mos. ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Dr. A. M. Nuston M. D.
April 29, 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Cemetery — DATE OF BURIAL: April 30 1914
20. UNDERTAKER: The Walker Undertaking Co. — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24
County of Bannock Primary Registration District No. 24
City of Pocatello (No. 552 S Second St.)
File No. 4 7791
Registered No. 155
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wallace Early Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 24 (Day) 1913 (Year)

7. AGE: yrs. 8 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: L W Johnson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Miss Early

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) 552 S Second

15. Filed Apr 8th 1914 O B Seeley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 7 (Day) 5 PM 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Apr 7 1914
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O B Seeley M. D.
4-7-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: April 8 1914

20. UNDERTAKER: Crawford and Edmunson — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 910, S. Main St.)
Registration District No. 84
Primary Registration District No. 2141
File No. 4710
Registered No. 157
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Earl Robert Morrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: May (Month) 2 (Day) 1913 (Year)
7. AGE: # yrs. 11 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): California
10. NAME OF FATHER: W. R. Morrison
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Elizabeth E. Brockholdt
13. BIRTHPLACE OF MOTHER (State or Country): Ill
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Morrison
(Address) 910 S. Main St
15. Filed May 7 1914 O. J. Stacy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 14 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mch 15 1914, to Apr 14 1914, that I last saw h[illegible] alive on Apr. 6th 1914, and that death occurred on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 20 ds.
(Signed) Frances H. Poole M. D.
Apr 14 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. ..... ds. In the State ..... yrs. 3 mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence. California

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Apr 15 1914
20. UNDERTAKER: The Walker Undertaking Co — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4793

Registered No. 158

1. PLACE OF DEATH.
County of Bannock
City of Pocatello 2d. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Elizabeth Cayling.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
March (Month) 5 (Day) 1863 (Year)

7. AGE
51 yrs. 1 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER James Christenson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Karen E.

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Siggie Fredricksen
(Address) Newton Utah

15.
Filed May 7th 1914 O B Lacey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1914, to April 16 1914 that I last saw h.er alive on April 16 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of duodenum

(Duration) 9 yrs. ..... mos. ..... ds.

Contributory (Secondary) 9

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Francis N Poole M. D.
Apr 18 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt View Cemetary — DATE OF BURIAL 4/19 1914

20. UNDERTAKER The Walker Undertaking Co — ADDRESS Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 4794
Registered No. 759

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Reilly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Divorced

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed May 7 1914 ..... Local Registrar

SYMS - YORK CO., PRES. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1914, to April 18 1914, that I last saw him alive on April 18 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Myocarditis with Uremia of Chronic nature.

(Duration) Several Yrs. ..... mos. ..... ds.
Contributory (Secondary) Broken compensation
(Duration ..... yrs. one mos. ..... ds.
(Signed) Dr A.M. Newton M. D.
April 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt View Cemetary — DATE OF BURIAL 4/21 1914

20. UNDERTAKER The Walker Undertaking Co — ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. 528, W-Fremont St.)

File No. 4705

Registered No. 168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dawson T. Jessee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 30 (Day) 1882 (Year)

7. AGE: 31 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M Baer

(Address) Pocatello Ida.

15. Filed May 7, 1914 — Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 19 1914, to Apr. 19 1914, that I last saw h[illegible] alive on Apr. 19 1914, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

Duration 1 hr.

Contributory (Secondary) Chronic Nephritis

Duration 1 yrs. mos. ds.

(Signed) [illegible] M. D.

April 19 1914 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH, or in deaths from violence, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Centralia Ill — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: The Walker Undertaking Co. — ADDRESS: Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7796

Registered No. 161

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 434 W. Wyeth Ave. Str.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

2. FULL NAME Emma J. Dahan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 29 (Day) 1873 (Year)

7. AGE: 40 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wis

10. NAME OF FATHER P. P. Peterson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Mary ——

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. P. Dahan

(Address) Pocatello, Idaho

15. Filed May 7, 1914 O. P. Dahan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 years up to 1914, to after 21st 1914, that I last saw her alive on April 20th 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Castle M. D.

(Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Stanton Wis

DATE OF BURIAL: .....191.....

20. UNDERTAKER: The Walker Undertaking Co.

ADDRESS: Pocatello Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 423 E. Carter St.)

File No. 4 770
Registered No. 163
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice B Knowles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: April (Month) 22 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. One ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Wilfred Knowles

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Susana B McDonald

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilfred Knowles
(Address) 423 East Carter St Pocatello

15.
Filed Apr 24 1914 O B Sivey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1914, to April 23 1914, that I last saw her alive on April 23 1914, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:
Bowel trouble
(Duration) ..... yrs. ..... mos. Few hrs. ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Howard M. D.
4/24 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Archer Ida — DATE OF BURIAL: April 26 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 4779
Registered No. 164

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 416 S Johnson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen E. Hunter

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Jan 16 1852 (Month) (Day) (Year)

7. AGE: 62 yrs. 3 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Henry Thomas

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Mowity

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R A Hunter
(Address) 416 S Johnson Pocatello

15. Filed Apr 30 1914 O P Stine Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 30th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1911, to April 30 1914
that I last saw her alive on April 30 1914
and that death occurred on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) — yrs. — mos. 2 ds.
Contributory (Secondary) Nephritis Pulmonary tuberculosis
(Duration) 20 yrs. — mos. — ds.

(Signed) W. J. Howard M. D.
5/1 1914 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Detroit Mich	May 6 1914

20. UNDERTAKER	ADDRESS
Crawford and Schumacher	City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 4799
Registered No. 156

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William J Brew

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov 7 (Month) 1860 (Day) (Year)

7. AGE: 53 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry business, or dstablishment in which employed (or employer): R R

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John Brew

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs William J Brew
(Address) 953 N Harrison

15. Filed 4-14- 1914 O P Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10 1914, to 4-13 1914, that I last saw h[illegible] alive on 4-12 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart
secondary to pneumonia
of liver
(Duration) 2 yrs. - mos. - ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Roberts M. D.
4/13 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: apl 15, 1914

20. UNDERTAKER: Crawford & S — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
File No. 750
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Cambridge (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Seymour Greene

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Mar (Month) 27 (Day) 1832 (Year)

7. AGE: 82 yrs. 1 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A K [illegible]
(Address) Cambridge Ida.

15.
Filed May 24 1914
C E Schmidt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1913, to May 28 1914
that I last saw him alive on May 17 1914
and that death occurred on the date stated above, at 4:0 M.

The CAUSE OF DEATH* was as follows:
Cerebral Paralysis

(Duration) 5 yrs. 1 mos. 26 ds.
Contributory (Secondary) Senility
(Duration) yrs. mos. ds.

(Signed) C E Schmidt M. D.
May 23 1914 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida
DATE OF BURIAL: May 28 1914

20. UNDERTAKER: Jas Anderson
ADDRESS: Cambridge Ida

AYER-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Oxford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048 6
(No. ....., ... St.)

File No. 7-11
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1898 (Year)

7. AGE: 15 yrs. 5 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: On Farm with
(b) General nature of industry business, or dstablishment in which employed (or employer): Father

9. BIRTHPLACE (State or Country): Swan Lake Idaho

10. NAME OF FATHER: Andrew Anderson

11. BIRTHPLACE OF FATHER (State or Country): Brigham City Utah

12. MAIDEN NAME OF MOTHER: Kate Quigley

13. BIRTHPLACE OF MOTHER (State or Country): Swan Lake Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Anderson
(Address) Oxford Idaho

15.
Filed May 10 1914 Ellis Hacker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1914, to April 21 1914, that I last saw h[illegible] alive on April 21 1914, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia,
Pneumonia Lobar

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Pneumonia
(Duration) 5 yrs. ..... mos. ..... ds.
(Signed) Dale Ford M. D.
April 24 1914 (Address) Denver

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oxford Idaho
DATE OF BURIAL: April 23 1914

20. UNDERTAKER: no undertaker
ADDRESS: Oxford Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. A[illegible] 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7802

Name Willard Anderson

Date of Death April 21, 1914.

Cause of Death Pneumococcic Meningitis

Contributary Cause of death Lobar Pneumonia

(Sign here) Casper W Lund M.D.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7811
Registered No. 5

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ida E. Conover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sep (Month) 8 (Day) 1853 (Year)

7. AGE: 60 yrs. 8 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Byron Ill

10. NAME OF FATHER: Wm Osborn

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ida E Osborn

13. BIRTHPLACE OF MOTHER (State or Country): Byron Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) A. W. Conover

15. Filed May 13 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to May 10 1914 that I last saw h er alive on May 10 1914, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Chronic interstitial Nephritis

..... (Duration) Indefinite yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

May 12 1914 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: May 12 1914

20. UNDERTAKER: G. C. Landon
ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 7814
Registered No. 6

1. PLACE OF DEATH.
County of Canyon
City of Payette (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John L Sams

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1851 (Year)

7. AGE: 62 yrs. 8 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: John Sams

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chester Sams
(Address) Berwyn

15. Filed May 14 1914 J.C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1914, to May 12 1914, that I last saw him alive on May 12 1914, and that death occurred on the date stated above, at 8 1 M.

The CAUSE OF DEATH* was as follows:
Rocky Mountain Tick Fever

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O.H. Avey M. D.
5/14/1914 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence: Removal

19. PLACE OF BURIAL OR REMOVAL: Berwyn Neb. DATE OF ~~BURIAL~~: May 14 1914

20. UNDERTAKER: J. M. McCain ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PERS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis

City of Morrow

Registration District No. 50

Primary Registration District No. 2129

(No. ....., ... St.)

File No. 7211

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W Colbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 4 (Day) 1867 (Year)

7. AGE: 47 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Shepherman

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: George F Colbert

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Edna Whipple

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nancy Colbert

(Address) Flo Idaho

15. Filed May 15 1914 H C Parrish Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1912, to May 14 1914, that I last saw h.sm alive on May 14 1914 and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Pernicous anemia

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Parrish M. D.

5-15 1914 (Address) Flo Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morrow Cemetary — DATE OF BURIAL: 5-16 1914

20. UNDERTAKER: G.O Denham — ADDRESS: Westlake Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1511

Registered No. 3

1. PLACE OF DEATH.
County of Canyon
City of New Plymouth (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 7009

2. FULL NAME Infant Roy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: May (Month) 14 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many... 2 ...hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New Plymouth Ida

10. NAME OF FATHER Paul N. Roy.

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Daisy Bellmon

13. BIRTHPLACE OF MOTHER (State or Country) New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Paul N Roy
(Address) New Plymouth Ida -

15.
Filed ..... 191...
Wm J. Dysdale
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1914, to May 14 1914 that I last saw h[illegible] alive on ..... 1914, and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:
Immature foetal development

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Dysdale M. D.
May 15 1914 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth — DATE OF BURIAL: May 15 1914

20. UNDERTAKER: [illegible] — ADDRESS: New Plymouth

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7809
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Mary Elizabeth Saunders

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Aug (Month) 10 (Day) 1912 (Year)

7. AGE: 1 yrs. 9 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Portland

10. NAME OF FATHER: H D Saunders

11. BIRTHPLACE OF FATHER (State or Country): Calefornia

12. MAIDEN NAME OF MOTHER: Marquette Stanmon

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Saunders
(Address) Cambridge Ida

15. Filed April 1 1914 O E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see cause until after death 191 , that I last saw h alive on about 191 , and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Simeon Hopper M. D.
19 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: May 18 1914

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 88

Primary Registration District No. 2164

File No. 751

County of Washington

City of Cambridge Ida. (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaretta E Partridge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Feb (Month) 18 (Day) 1896 (Year)

7. AGE: 18 yrs. 7 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse Practice
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Allegania Co N. Y.

10. NAME OF FATHER: Adam Potts

11. BIRTHPLACE OF FATHER (State or Country): unknown.

12. MAIDEN NAME OF MOTHER: Margaret unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Partridge
(Address) Cambridge Ida

15. Filed Mar 9 191/ O Schuntz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1914, to Mar 9 1914, that I last saw her alive on Feb 3 1914, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Nephritis & Cardiac dilatation

(Duration) yrs. 1 mos. 15 ds.

Contributory (Secondary): old age and general Debility

(Duration) yrs. 2 mos. ds.

(Signed) O Schuntz M. D.

19 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Cambridge | DATE OF BURIAL: Mar 11 1914

20. UNDERTAKER: J A Hendleman | ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19750

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Custer
City of Mackay

Registration District No. 109
Primary Registration District No. 2187
(No. ....., ... St.)

File No. 7-1
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: August (Month) 23 (Day) 1869 (Year)

7. AGE: 44 yrs. 6 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): Employed

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Joseph John Nicks

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Eliza Grimma

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma E Nicks
(Address) Mackay Idaho

15. Filed 6/8 1914 F. P. Richards Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1913, to March 1914 that I last saw him alive on March 11" 1914 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH was as follows:
Miners Consumption
Con Thracosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Baker M.D.
3-11 1914 (Address) Mackay Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay — DATE OF BURIAL: 3-15" 1914

20. UNDERTAKER: Baker — ADDRESS: Mackay

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Fraser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 7168
(No. ....., ... St.)

File No. 7-1
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mildred Leona Abram

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Single (Never Married)

6. DATE OF BIRTH
Apr (Month) 24 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Baby
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho.

10. NAME OF FATHER Walter Abram

11. BIRTHPLACE OF FATHER
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER Emma Aubrey

13. BIRTHPLACE OF MOTHER
(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earle W Horswell
(Address) Orofino Ida

15.
Filed May 31 1914 J. McFarley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1914 to Apr 30 1914, that I last saw her alive on Apr. 30 1914 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Inspiration Pneumonia & a Malformation of Esophagus

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle W Horswell M. D.
May 31 1914 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fraser	May 3 1914

20. UNDERTAKER	ADDRESS
M C Stoddard	Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

County of Clearwater

Primary Registration District No. 7168

File No. 7913

City of Orofino

(No. ....., ... St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Not Named

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 2 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: J H Moftsger

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mable Helmberg

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Moftsger
(Address) .....

15. Filed May 5 1914 J. McInnis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1914, to May 4 1914, that I last saw h[illegible] alive on May 4 1914, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Imperforate anus

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Arrested development

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Daine M. D.

May 5 1914 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: May 6 1914

20. UNDERTAKER: H C Stoddard — ADDRESS: Gifford Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

File No. 784

County of Clearwater

City of Orofino. (No. ....., ... St.)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angus McLeod.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White	married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1860. (Year)

7. AGE

57 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New Jeland

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Givens

(Address) Orofino, Idaho

15. Filed May 11 1914 J. McFarley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3. 1914, to May 8 1914, that I last saw him alive on May 8 1914, and that death occurred on the date stated above, at 9. a.m. M.

The CAUSE OF DEATH* was as follows:

Acute Mania

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Givens M. D.

May 8 1914 (Address) Orofino. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Orofino. DATE OF BURIAL May 10 1914

20. UNDERTAKER C.H. Hill ADDRESS Orofino Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 7815
Registered No. 25
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter McCubbin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.)
Male	White	Widowed

6. DATE OF BIRTH: May (Month) 17 (Day) 1838 (Year)

7. AGE: 75 yrs. 11 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: John McCubbin

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Annie White

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. James Blake per ANT
(Address) Orofino Ida

15. Filed May 31 1914 J. M. Hardy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1, 1914 to May 1914 that I last saw h. alive on about May 1 1914 and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Acute Heart Failure - Chronic myocarditis Endocarditis with Chronic Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) /
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle M Horsnell M. D.
5/11 1914 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence /

19. PLACE OF BURIAL OR REMOVAL: Portland — DATE OF BURIAL: 5/ 1[illegible] 1914

20. UNDERTAKER: W. C. Stoddard — ADDRESS: Gifford

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

File No. 7816

County of Clearwater

City of Orofino (No. ....., ... St.)

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William McMillan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 13 (Day) 1839 (Year)

7. AGE: 74 yrs. 7 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): X

10. NAME OF FATHER: Wm McMillan

11. BIRTHPLACE OF FATHER (State or Country): X

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): ~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Gamble
(Address) Nezperce Idaho

15. Filed May 31 1914 J. M. Farley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1913 to May 27 1914, that I last saw him alive on May 27 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory ~
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Farley M. D.

May 31 1914 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: May 29 1914

20. UNDERTAKER: W. C. Stoddard — ADDRESS: Gifford Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 7168

File No. 7817

County of Shoshone

City of Lenore (No. ....., ... St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie Furman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 22 (Day) 1862 (Year)

7. AGE: 51 yrs. 8 mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill DeKalb

10. NAME OF FATHER: Oliver Furman

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Laveta Shaul

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Patterson
(Address) Lenore Idaho.

15. Filed May 31 1914 J. M. Hanley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 15 1914, to July 8 1914, that I last saw h[illegible] alive on July 8 1914, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Hanley M. D.

May 31 1914 (Address) Prospect, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone County | DATE OF BURIAL: June 1 1914

20. UNDERTAKER: P. C. Goddard | ADDRESS: Clifford Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2165
File No. 781
Registered No. 38

1. PLACE OF DEATH.
County of Clearwater
City of Orino (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Byron Sheeps.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	widower

6. DATE OF BIRTH
..... (Month) ..... (Day) 1860 (Year)

7. AGE
54 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Va,

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John G. Givens
(Address) Orofino, Ida

15. Filed May 31 1914 J. M. Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 31. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1914, to May 31. 1914, that I last saw him alive on May 31 1914, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) 11 yrs. ..... mos. ..... ds.

(Signed) John G. Givens M. D.

May 31 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Orofino, Idaho | DATE OF BURIAL June 2 1914

20. UNDERTAKER W. C. Stoddard | ADDRESS Orofino, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
- BOARD OF HEALTH
Bureau of Vital Statistics

File No. 781

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Blaine

City of Hill City

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amos Hayzard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 27 (Day) 14 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Blaine Co. Ida

10. NAME OF FATHER: Frank Leroy Hayzard

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Lilie Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O R Blossom

(Address) Hill City

15.

Filed 5-28 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1914, to May 27 1914 that I last saw h[illegible] alive on May 27 1914 and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:

Acute Mania

(Duration) — yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

5/28 1914 (Signed) O R Blossom M. D.

(Address) Hill City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hill City

DATE OF BURIAL: 5-28 1914

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 58

County of Blaine

Primary Registration District No. 2138

File No. 196

City of Hailey

(No. ....., ... St.)

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. M. Hester

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 16 (Day) 1871 (Year)

7. AGE: 42 yrs. 11 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry business, or dstablishment in which employed (or employer): Hardware

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Joel Hester

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Jane Starbuck

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence B. Hester
(Address) Hailey Idaho

15. Filed May 28 1914 D. Heggy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1914, to May 27 1914, that I last saw h[illegible] alive on May 18 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Heggs M. D.

4-27-1914 (Address) Baldwin Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 1914

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7[illegible]
Registered No.

1. PLACE OF DEATH.
County of Lewis.
City of Kamiah.

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Connie Mable Conein

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 15 (Day) 1890 (Year)

7. AGE: 23 yrs. 5 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana.

10. NAME OF FATHER: Herbert Tomkins.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Annie Avery.

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Edsie Avery.
(Address) Kamiah Idaho.

15.
Filed 5/28 1914 W. F. McMeahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/7 1914, to 5/24 1914
that I last saw h[illegible] alive on 5/24 1914
and that death occurred on the date stated above, at 10:10 P.M.

The CAUSE OF DEATH* was as follows:
Mitral Incompetency
..... (Duration) 3 yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism
..... (Duration) 3/4 yrs. ..... mos. ..... ds.

(Signed) C. J. Bryan M. D.
5/27 1914 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Butte Mont.
DATE OF BURIAL: May 28 1914

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

File No. 782
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruby Adkison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
May (Month) 23 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kamiah Idaho.

10. NAME OF FATHER J R Adkison

11. BIRTHPLACE OF FATHER (State or Country) Oregon.

12. MAIDEN NAME OF MOTHER Edith Johnson.

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J R Adkison
(Address) Kamiah, Idaho.

15.
Filed 5/30 1914 W. J. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
5 (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/23 1914, to 5/29 1914, that I last saw her alive on 5/28 1914, and that death occurred on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:
Interus & exhaustion due to incipient Circulation
..... (Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. McMahan M. D.
5/29 1914 (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
I. O. O. F. Cemetery	May 30 1914

20. UNDERTAKER	ADDRESS
C. J. Johnson	Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 782

1. PLACE OF DEATH.
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ql-la-lim-wil-mum-my Blackeagle

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: don't know ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 63 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Elute-pa-aih-yam.

11. BIRTHPLACE OF FATHER (State or Country): don't know

12. MAIDEN NAME OF MOTHER: don't know

13. BIRTHPLACE OF MOTHER (State or Country): don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Blackeagle
(Address) Kamiah, Idaho

15.
Filed 6/8 1914 J.F. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31st 1914, to May 18th 1914 that I last saw her alive on May 18th 1914 and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis
also of the other viscera

..... (Duration) 1 yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W.E. McMahan M. D.
6/8 1914 (Address) Kamiah.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind Cemetery No. 2
DATE OF BURIAL: 6/8 1914

20. UNDERTAKER: C.J. Johnson
ADDRESS: Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7891

Registered No. 14

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Saphernia J. Fuller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 17 (Day) 1863 (Year)

7. AGE: 51 yrs. 1 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Ira Blackmar

11. BIRTHPLACE OF FATHER (State or Country): R. I.

12. MAIDEN NAME OF MOTHER: Crofett

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Fuller
(Address) Harrison

15. Filed June 8 1914 — R. S. Jensen, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1914, to May 27 1914, that I last saw her alive on May 2 1914 and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Tumor and Chronic septic Peritonitis.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Flannery M. D.
May 27 1914 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison on the Farm
DATE OF BURIAL: May 29 1914

20. UNDERTAKER: E. W. Wheeler
ADDRESS: Harrison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 'CAUSE OF DEATH' in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 782
Registered No. 19

1. PLACE OF DEATH.
County of Kootenai
City of Rose Lake
Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evander N Leonard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 14 (Day) 1850 (Year)

7. AGE: 64 yrs. 1 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E.V. Robertson
(Address) Rose Lake Ida

15. Filed May 10 1914 R.S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1913, to April 27 1914
that I last saw him alive on April 27 1914
and that death occurred on the date stated above, at 11 20a M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Nov yrs. 14 mos. 1913 ds.

Contributory (Secondary) ✓

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Worthington M. D.
April 28 1914 (Address) Rose Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? ✓
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: 2½ Miles North Rose Lake — DATE OF BURIAL: April 29 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace

Jnd

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 120

County of Canyon

Primary Registration District No. 1199

City of Basin

(No. ....., ... St.)

File No. 4 782

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Arid Montlue

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Feb. 27 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joel Montlue

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Edith G. Owens

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joel Montlue
(Address) Gracie, Basin Ida

15. Filed 5/18 1914 E P Wohlen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May. 16 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1913 to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Convulsions from
Pertussis

(Duration) 2 yrs. 2 mos. 14 ds.

Contributory (Secondary)

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) ..... M. D.

May 18 1914 (Address) Joel Montlue Basin Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Basin Idaho — DATE OF BURIAL: 5-18 1914

20. UNDERTAKER: A Sagers — ADDRESS: Basin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. II *7827
Registered No. 10

1. PLACE OF DEATH.
County of Cassia
City of Oakley
Registration District No. 120
Primary Registration District No. 3199
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Armintia Despain Workman
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug. 28. 1854 (Month) (Day) (Year)

7. AGE: 59 yrs. 9 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James Despain

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Celia Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Nelson
(Address) Oakley Idaho

15. Filed June 9 1914 E P Oldham
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 9 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1907, to June 9 1914, that I last saw her alive on June 9 1914, and that death occurred on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:
General secondary carcinomatosis

(Duration) 7 yrs. 2 mos. ds.
Contributory (Secondary) Myocarditis
(Duration) yrs. mos. 3 ds.

(Signed) E P Oldham M.D.
6/9 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho
DATE OF BURIAL: 6-10 1914

20. UNDERTAKER: H C Haight
ADDRESS: Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9 7828

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

County of Idaho

City of Cottonwood (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernard P Duffy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH: April (Month) 14 (Day) 1839 (Year)

7. AGE: 75 yrs. 1 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Attorney at Law
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Loughrea Ireland

10. NAME OF FATHER: Peter Duffy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs B. P. Duffy
(Address) Cottonwood Idaho

15.
Filed May 19 1914 H Bosler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3rd 1914 to May 17 1914 that I last saw h sm alive on May 17 PM. 1914 and that death occurred on the date stated above, at 7.50 A.M.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency due to
Chronic Interstitial Nephritis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Cerebral Hemorrhage
..... (Duration) — yrs. 1 mos. 12 ds.

(Signed) Wesley F. Orr M. D.
May 18 1914 (Address) Cottonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Catholic Cemetery Cottonwood Idaho
DATE OF BURIAL: May 20 1914

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 51
Primary Registration District No. 2130
File No. 1 7829
Registered No. 2

1. PLACE OF DEATH.
County of Canyon
City of Fruitland
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Neal
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Dec 25 1835 (Month) (Day) (Year)

7. AGE: 78 yrs. 4 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Jesse Neal

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Elizabeth Ballow

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Williams
(Address) Fruitland Idaho

15. Filed June 10 1914 Cirpin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (17th) 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1912., to May 1914, that I last saw him alive on April 12th 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis + arteriosclerosis

(Duration) 2 yrs. ~ mos. ~ ds.
Contributory (Secondary) Old age
(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) Wm. T. Dysdale M. D.
May 18 1914 (Address) New Plymouth (by Cirpin Wright)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: J. H. Farley
ADDRESS: Ontario Ore

Ment or OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 7-35
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Lambert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April 25th 1841
(Month) (Day) (Year)

7. AGE: 73 yrs. 1 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Durham Maine US

10. NAME OF FATHER: Joshua Lambert

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Susan Gardner

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John McBoyle
(Address) Grangeville Idaho

15. Filed June 2nd 1914 G S Stockton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 19760

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 2 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to June 1 1914, that I last saw h[illegible] alive on June 1 1914, and that death occurred on ~~the date~~ June 2 stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

[illegible] Cerebral Hemorrhage

(Duration) 14 yrs. ——— mos. ——— ds.

Contributory (Secondary) Involvement of Pharynx with resulting paralysis

(Duration) ——— yrs. ——— mos. ——— ds.

(Signed) C. V. Thrasher M. D.

June 2 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: June 3 1914

20. UNDERTAKER: W E Graham | ADDRESS: Grangeville

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. .....
Registered No. 15
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thomas Ward Gurlon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widowed

6. DATE OF BIRTH: June (Month) 11 (Day) 1832 (Year) ~~1832~~

7. AGE: 82 yrs. 5 mos. 3 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana Rush Co

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Grangeville Ida,

15. Filed June 2 1914 G B Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191...
that I last saw h— alive on ~ 191...,
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Found dead in garden

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G B Stockton M. D.
May 15 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Linton Ranch
DATE OF BURIAL: May 16 1914

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1007
(No. ....., ... St.)

File No. 7832
Registered No. 14
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice A. Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
July [illegible] 14 1869
(Month) (Day) (Year)

7. AGE
44 yrs. 9 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Dressmaker
(b) General nature of industry business, or establishment in which employed (or employer) Employer

9. BIRTHPLACE
(State or Country) Pennsylvania

10. NAME OF FATHER
[illegible] Miller

11. BIRTHPLACE OF FATHER
(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER
Ann Brown

13. BIRTHPLACE OF MOTHER
(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Miller
(Address) Cottonwood Idaho

15.
Filed June 2 1914 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 13 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1914, to May 6 1914, that I last saw her alive on May 6 1914, and that death occurred on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Duration) 6 yrs. 6 mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) W. H. Warner M. D.
5-13-1914 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood
DATE OF BURIAL: 5-16 1914

20. UNDERTAKER: W E Graham
ADDRESS: Grangeville Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. .....
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH
May (Month) 26 (Day) 1914 (Year)

7. AGE
— yrs. — mos. — ds.
IF LESS than 1 day how many ..12.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W H Vincent

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Berle B McDonald

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W H Vincent
(Address) Grangeville Ida

15.
Filed June 2 1914 G B Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1914, to May 27 1914, that I last saw him alive on May 26 1914, and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G B Stockton M. D.
May 27 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Idaho	May 27 1914

20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 7834
Registered No. 17
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Not Named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	Single

6. DATE OF BIRTH
May (Month) 26 (Day) 1914 (Year)

7. AGE
— yrs. — mos. 2 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W. H. Vincent

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Berle B McDonald

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W H Vincent
(Address) Grangeville Ida

15.
Filed June 2 1914 G B Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1914, to May 28 1914
that I last saw h— alive on May 28 1914
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G B Stockton M. D.
May 29 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho
DATE OF BURIAL: May 29 1914

20. UNDERTAKER: None
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Insane Asylum St.)

File No. 783
Registered No. 25
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ah Gun

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Mongolian	Don't Know

6. DATE OF BIRTH Don't Know 1.
(Month) (Day) (Year)

7. AGE 76 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. E. Hyde
(Address) Blackfoot Idaho

15. Filed April 9 1914 M. E. Parkin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 9 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4th 1914, to April 9 1914, that I last saw h— alive on April 9th 1914, and that death occurred on the date stated above, at 4-0 P.M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) — yrs. — mos. 5 ds.

Contributory (Secondary) Senile Dementia

(Duration) — yrs. — mos. — ds.

(Signed) Geo. E. Hyde M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs. 1 mos. 20 days. In the State 48 yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? —

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: ..... 191..

20. UNDERTAKER Geo. E. Hyde — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Sterling
If death occurred outside city limits or town, give residence; give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 7536
Registered No. 96
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lydia Eliza Snyder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 16 1857 (Month) (Day) (Year)

7. AGE: 56 yrs. 7 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario

10. NAME OF FATHER: John D Snyder

11. BIRTHPLACE OF FATHER (State or Country): Ontario

12. MAIDEN NAME OF MOTHER: Lucinda Cole

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur J Snyder
(Address) Springfield Idaho

15. Filed May 12 1914 — W. E. Tatro, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1914, to May 10 1914, that I last saw her alive on May 6 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancer of uterus.
Carcinoma.

(Duration) yrs. 14 mos. — ds.
Contributory (Secondary): Ascites
(Duration) — yrs. 6 mos. — ds.
(Signed) W. E. Tatro M. D.
May 11 1914 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: May 12 1914

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2192
(No. ....., ... St.)

File No. 7837
Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Unnamed Berg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Never married)

6. DATE OF BIRTH: May (Month) 13 (Day) 1914 (Year)

7. AGE: ___ yrs. ___ mos. 2 hours
IF LESS than 1 day how many 2 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ———
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Blackfoot R F D 2

10. NAME OF FATHER: Swan Berg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lulu Burke

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Davis
(Address) Blackfoot

15. Filed May 14 1914 M E Fabrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 191..., to May 13 1914
that I last saw her alive on May 13 1914
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Undeveloped infant

(Duration) ..... yrs. ..... mos. 2 hrs.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Davis M. D.
5-13 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery Berg — DATE OF BURIAL: May 15 1914

20. UNDERTAKER: Swan Berg — ADDRESS: Blackfoot R 2 Box 82

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 2194
File No. 75
Registered No. 28

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aurilla Packwith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. July 14 (Month) (Day) 1825 (Year)

7. AGE: 88 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cleveland Ohio

10. NAME OF FATHER: Cazad

11. BIRTHPLACE OF FATHER (State or Country): do not know

12. MAIDEN NAME OF MOTHER: Aurilla Cazad

13. BIRTHPLACE OF MOTHER (State or Country): do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr C E Bryant
(Address) Blackfoot Idaho

15. Filed May 18 1914 M E Fahrie Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1914, to May 16 1914, that I last saw her alive on May 16 1914, and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Exhaustion after an attack of La Grippe followed by Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr C E Bryant M. D.
5/27 1914 (Address) Bingham County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Idaho
DATE OF BURIAL: 1914

20. UNDERTAKER: E Funk
ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham — Registration District No. 121

City of Blackfoot — Primary Registration District No. 2104

(No. ..... , ... St.)

File No. 7834

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hermann Kuhlhoff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 10 (Month) 12 (Day) 1888 (Year)

7. AGE: 25 Yrs. 7 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Well Driller
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Calhoun Co. Ill

10. NAME OF FATHER: Bernard Kuhlhoff

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Margaret Ernster

13. BIRTHPLACE OF MOTHER (State or Country): Calhoun Co Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Kuhlhoff
(Address) Congress Idaho

15. Filed May 26 1914 — M. E. Tabor, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1914

17. I HEREBY CERTIFY, That I attended deceased from May 11 1914, to May 21 1914, that I last saw him alive on May 21 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Septicaemia

..... (Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Crushed foot

..... (Duration ..... yrs. ..... mos. 14 ds.

(Signed) F. M. Mitchell M. D.

May 26 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days In the State .....yrs .....mos .....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ross Okla — DATE OF BURIAL: 191

20. UNDERTAKER: E. F. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

File No. 754

County of T...

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Rachel Maxwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	

6. DATE OF BIRTH. Nov (Month) 30 (Day) Friday 1913 (Year) 1914

7. AGE ..... Yrs. 5 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Morden Maxwell

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Elizabeth Rachel Fox

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane B. Maxwell

(Address) Twin Falls.

15. Filed 5-23 1914 Jno. W. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 22 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1914, to May 22 1914, that I last saw h[illegible] alive on May 22 1914 and that death occured on the date stated above, at 9 30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Hamilton M. D.

May 23 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Twin Falls	5-23 1914
20. UNDERTAKER	ADDRESS
Chas. J. Crosby	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

File No. 741

County of Twin Falls

Primary Registration District No. 1055

City of Murtaugh (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Troy H Stevenson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April 21 1913 (Month) (Day) (Year)

7. AGE: 1 yrs. 0 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Milner Idaho

10. NAME OF FATHER John D Stevenson

11. BIRTHPLACE OF FATHER (State or Country) Nebr.

12. MAIDEN NAME OF MOTHER Della F. Sautter

13. BIRTHPLACE OF MOTHER (State or Country) Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L C Patterson

(Address) Milner Ida

15. Filed May 21 1914 John D. Cuplin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 20th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17th 1914, to May 20th 1914, that I last saw him alive on May 19th 1914, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

5-20 1914 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Murtaugh — DATE OF BURIAL: May 21 1914

20. UNDERTAKER: L. F. Stevenson — ADDRESS: Twin Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 37 Bureau of Vi...
County of Twin Falls Primary Registration District No. 1085 File No. 784
City of " " (No. ..., ... St.) Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Gabioud

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH. July 7th 1859 (Month) (Day) (Year)

7. AGE: 54 Yrs. 10 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Peter Gabioud

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Mary Gabioud

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Pauline Gabioud
(Address) Twin Falls Ida

15. Filed 5-19 1914 John T. Douglas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1913, to May 18 1914, that I last saw him alive on May 11 1914, and that death occured on the date stated above, at 3 A. M.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) Yrs. 3 mos. ds.
Contributory (Secondary) Septic Infection of Bladder prostate & Kidney
(Duration 15 yrs. mos. ds.
(Signed) J. R. Morgan M. D.
May 19 14 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: 5/19 1914
20. UNDERTAKER: Chas J Crosby | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STUB - YORK CO., PTRS. & MFRS. 24689

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 7844
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grant Radcliff Blystone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 4th (Day) 1911 (Year)

7. AGE: 3 Yrs. 3 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER O. L. Blystone

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Bessie Price

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. A. Reynolds
(Address) Filer Idaho

15. Filed 5-11 1914
John F. Crouch
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1914, to May 11 1914, that I last saw him alive on May 10 1914, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Measles
.....
.....
.....(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) American
.....(Duration ..... Yrs. ..... mos. ..... ds.
(Signed) J. Mountford M. D.
19..... (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Filer Ida	5/11 1914
20. UNDERTAKER Chas J. Crosby	ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of " "

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 784

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecil James Bozarth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 29 (Day) 1908 (Year)

7. AGE: 6 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Home

(b) General nature of industry, business or establishment in which employed (or employer)... None

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER E. J. Bozarth

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Anna Florence Coy

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. J. Bozarth

(Address) Twin Falls.

15. Filed 5-5 1914

John J. Bagley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1914, to May 5 1914, that I last saw h-- alive on May 5 1914, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Nelson M. D.

May 6 1914 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 5-6 1914

20. UNDERTAKER: Chas J Crosby — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & ROBS. 24658

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7845

Name Cecil James Bozarth

Date of Death May 5. 1914.

Cause of Death Broncho Pneumonia

Contributary Cause of death ———

(Sign here) H W Wilson M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7846

Registered No. .....

1. PLACE OF DEATH

County of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

City of ..... (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucile Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June 30 (Month) (Day) 1912 (Year)

7. AGE: 1 Yrs. 10 Mos. 7 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER A G Wilson

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Adam

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A M Baird

(Address) .....

15. Filed 5-4 1914 John F Caufield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2nd (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased fr 4/27 1914, to 5/2 1914

that I last saw her alive on 5/2 1914

and that death occured on the date stated above, at 11:30 A.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) measles

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Weaver M. D.

5/4 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: 5-4 1914

20. UNDERTAKER: C J Crosby

ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & SEAS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34

Primary Registration District No. 2020

File No. 784

Registered No. 15

County of Elmore

City of Emmett Precinct

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Granville W. Hackett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

about 46 yrs. — mos. — ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... farmer .....

(b) General nature of industry business, or dstablishment in which employed (or employer) ..... worked for Forest .....

9. BIRTHPLACE

(State or Country) Kentucky

10. NAME OF FATHER — —

11. BIRTHPLACE OF FATHER

(State or Country) — —

12. MAIDEN NAME OF MOTHER — —

13. BIRTHPLACE OF MOTHER

(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna R Wilson

(Address) Mtn Home Ida.

15.

Filed May 19th 1914 Bwmather
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 18 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to May 18 1914, that I last saw h— alive on May 17, 11 Pm 1914, and that death occurred on the date stated above, at 12 6 AM.

The CAUSE OF DEATH* was as follows:

Had had Spotted fever (Rocky Mtn Tick fever) I got up too soon Causing trouble with heart (Duration) — yrs. — mos. 13 ds.

Contributory (Secondary) Myocarditis

(Duration) — yrs. — mos. 17 ds.

(Signed) W L Graziers M. D.

5 18 1914 (Address) Mtn Home, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn Home	May 19 1914

20. UNDERTAKER	ADDRESS
J M Conaw	Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 34
County of Elmore
Primary Registration District No. 2020
File No. 784
City of Mountain Home (No. ..... St.)
Registered No. 13
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME John Seth Heath

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1905 (Year)

7. AGE: 8 yrs. 6 mos. 7 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Mountainhome Idaho

10. NAME OF FATHER Guy S. Heath

11. BIRTHPLACE OF FATHER (State or Country) Kan

12. MAIDEN NAME OF MOTHER Louse. Leavy

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Atlanta Yeats
(Address) Mountain Home

15. Filed May 6th 1914 Blondalker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3d 1914, to May 5th 1914, that I last saw him alive on May 5th 1914, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
General Peritonitis, from ruptured appendix - post operative
(Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Idaho Tick fever
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) Blondalker M. D.
5/6 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountainhome Ida | DATE OF BURIAL: May 7 1914

20. UNDERTAKER: J M Cowen | ADDRESS: Mountain Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34

County of Elmore

Primary Registration District No. 2020

File No. 7849

City of Pine (No. ..... St.)

Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Thomas Nicholson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
m	w	married

6. DATE OF BIRTH March 15. 1837.
~~May Oct 9~~ (Month) (Day) 1914 (Year)

7. AGE 63 yrs. ..... mos. 1 ds. 25 — IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farming
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri.

10. NAME OF FATHER John F. Nicholson

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Eunice Frances

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Thomas Nicholson
(Address) Pine Ida

15.
Filed May 1914 B.W. Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1914, to May 8 1914;
that I last saw h[illegible] alive on May 8 1914,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Heart Failure
Apr. 20th had broken leg
Died in night on May 9th
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) No Physician ever in attendance
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) B.W. Mather M. D.
19 ..... (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State 30 yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pine	May 11 1914

20. UNDERTAKER	ADDRESS
Friends only	Pine

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 755

Registered No. 12

1. PLACE OF DEATH. Registration District No. 34

County of Elmore Primary Registration District No. 2020

City of Pine Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Edward Nicholson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: June (Month) 1 (Day) 1873 (Year)

7. AGE: 38 yrs. 11 mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: J A Nicholson

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Mourlda J Caldwell

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C M Nicholson
(Address) Mountain Home

15. Filed May 3d 1914 B O Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to May 2 1914 that I last saw h in alive on don't remember 1914 (Date) and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

An acute attack of ~~Pneumonia~~ Catarrhal, following a Chronic Condition of Sams

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W L Faucin M. D.

5-3 1914 (Address) Mtn Home Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mountainhome — DATE OF BURIAL: May 4 1914

20. UNDERTAKER: J M Owen — ADDRESS: Mountainhome

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Mountainhome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020
(No. ..... St.)

File No. 785
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter J. Underwood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
June (Month) 27 (Day) 1871 (Year)

7. AGE
43 yrs. 10 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Foreman Ranch
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Wm J Underwood

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Cacelia Baldry

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alice C. Shupe
(Address) Idaho Falls Ida

15.
Filed R F D 191 Ro 1 Box 118
May 4th 1914 B.W.Mathes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 1st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15th 1914, to May 1st 1914, that I last saw h Wm alive on May 1st 1914, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Idaho Tick fever —
(Duration) ..... yrs. ..... mos. 16 ds.
Contributory (Secondary) Oedema of lungs
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) B.W.Mathes M. D.
5/4 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountainhome | DATE OF BURIAL: May 5 1914

20. UNDERTAKER: J.M. Cowan | ADDRESS: Mountain Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 .20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell Rural. (No. ....., ... St.)

File No. 7852

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Anna Segrig Vassar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Nov (Month) 10 (Day) 1842 (Year)

7. AGE: 71 yrs. 5 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Franklin Co. Missouri

10. NAME OF FATHER: Jesse Segrig

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillie Vassar
(Address) Caldwell Ida

15. Filed May 11 1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 30 1914, to May 9th 1914, that I last saw h er alive on May 9th. 1914, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Diabetis Insipidus

(Duration) Several yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Garner, M. D.

May 9 1914 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: May 11 1914

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 785

Registered No. 30

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Caldwell Rural (No. Leonidas (F.S.M) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonidas Whitemore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal

4. COLOR OR RACE: Whit

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apl. (Month) 8 (Day) 1870 (Year)

7. AGE: 44 yrs. 1 mos. 7 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: J. J. Whitemore

11. BIRTHPLACE OF FATHER (State or Country): Dutch Prussia

12. MAIDEN NAME OF MOTHER: Mary E. Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida E. Whiteman
(Address) Caldwell Rural # 4

15.
Filed May 18 1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1914, to May 11 1914, that I last saw h[illegible] alive on May 11 1914 and that death occurred on the date stated above, at 7.05 A. M.

The CAUSE OF DEATH* was as follows:
Diabetes Insip. –

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) F. D. Farris M. D.
May 19 14 (Address) Caldwell –

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: May 19 1914

20. UNDERTAKER: W. G. Dyer — ADDRESS: Caldwell

Idaho

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 185
Registered No. 32

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy A Munson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Nov 17 1873
(Month) (Day) (Year)

7. AGE: 40 yrs. 6 mos. 8 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Geneseo Ill

10. NAME OF FATHER: Perry Munson.

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A A Faris
(Address) Caldwell

15. Filed May 27th 1914. John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25 1913, to May 25 1914 that I last saw h[e] alive on May 25 1914, and that death occurred on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:
Loc. 2 Hem resulting in Paralysis

(Duration) Many yrs. ..... mos. ..... ds.
Contributory (Secondary) Nephritis
(Duration) ..... yrs. Several mos. ..... ds.

(Signed) M. Mc Call M. D.
5/25 1914 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery Payette Idaho
DATE OF BURIAL: May 27 1914

20. UNDERTAKER: W. E. Dye
ADDRESS: Caldwell. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 785
Registered No. 33

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Tucker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: May (Month) 21 (Day) 1914 (Year)

7. AGE: ... yrs. ... mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canyon Co Ida

10. NAME OF FATHER: M. L. Tucker

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Martha L. Jay

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. L. Tucker
(Address) Caldwell Ida

15. Filed May 26 1914 John D. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1914, to May 26 1914
that I last saw him alive on May 26 1914
and that death occurred on the date stated above, at 11 32 A.M.

The CAUSE OF DEATH* was as follows:
Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Coll M. D.
5/26 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenleaf — DATE OF BURIAL: May 27 1914

20. UNDERTAKER: Peckham Care Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Middleton (No. ....., ... St.)
File No. 7858
Registered No. 34
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Chenoweth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1847 (Year)

7. AGE: 66 yrs. 6 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Madison Co. Iowa

10. NAME OF FATHER: Daniel Chenoweth

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Butler

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L E Chenoweth
(Address) Caldwell Ida

15. Filed 6/4/1914 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 1914, to June 1914, that I last saw him alive on May 26 1914, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Brights Disease

(Duration) yrs. 4 mos. 25 ds.
Contributory (Secondary) Mitral regurgitation
(Duration) yrs. 4 mos. 25 ds.

(Signed) Jno Laurer M. D.
6-2-1914 (Address) Middleton Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Dayton Wash.
DATE OF ~~BURIAL~~: June 4 1914

20. UNDERTAKER: W.C. Dyer
ADDRESS: ~~W.C. Dyer~~ Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. (15)
Registered No. 331

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. Rural — St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Jannette King

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 20 (Day) 1847 (Year)

7. AGE: 66 yrs. 6 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: John Johnston

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margret Adair

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. King
(Address) Caldwell Idaho

15. Filed 6/4/1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1914, to June 2 1914
that I last saw her alive on June 2 1914
and that death occurred on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
of heart

(Duration) ..... yrs. 6 mos. ..... ds.
Contributory (Secondary) Senile Trouble
(Duration) 3d yrs. — mos. — ds.

(Signed) J. W. Farmer M. D.
6-4 1914 (Address) Middleton Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 6/4 1914

20. UNDERTAKER: Peckham Core Co. ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7860
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Whitebird
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John B Crooks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Ma
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1854 (Year)

7. AGE: 59 yrs. 6 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: John McCrooks

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Martha Pea.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Crooks
(Address) Whitebird Ida.

15.
Filed June 191.... W A Foskett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1913, to May 28 1914, that I last saw him alive on May 26 1914, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
Mitral Trouble
Heart failure
(Duration) ... yrs. 6 mos. — ds.

Contributory (Secondary) —
(Duration) ... yrs. ... mos. ... ds.

(Signed) W A Foskett M. D.
May 30 1914 (Address) Whitebird Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grangeville — DATE OF BURIAL: May 30 1914

20. UNDERTAKER: Hancock — ADDRESS: Grangeville

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

STANDARD STATE CERTIFICATE OF DEATH. Fill in plain terms, so that it may be properly classified. See instructions on back of certificate. ment of OCCUPATION is very important.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7861
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Juliaetta
(No. ....., ... St.)
Registration District No.
Primary Registration District No. 2148
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Sophia Stumps.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widow

6. DATE OF BIRTH: April (Month) 11 (Day) 1834 (Year)

7. AGE: 80 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio,

10. NAME OF FATHER: Jacob Hildebrand.

11. BIRTHPLACE OF FATHER (State or Country): Penna.

12. MAIDEN NAME OF MOTHER: Dont know.

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Stumps
(Address) Juliaetta, Ida.

15.
Filed May 8th 1914 — S. A. Roe, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 12 1914, to May 5 1914, that I last saw her alive on May 5th 1914 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) 1 yrs. 6 mos. — ds.

Contributory (Secondary)
(Duration) — yrs. ..... mos. ..... ds.

(Signed) S. A. Roe M. D.
May 8, 1914. (Address) Juliaetta, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Juliaetta, Ida. DATE OF BURIAL: May 8 1914

20. UNDERTAKER: J. E. Groceclose ADDRESS: Juliaetta, Ida

Lewiston No 5-8

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 52
County of Bear Lake Primary Registration District No. 2136.
City of Montpelier (No. ....., ... St.)
File No. 7845
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Brady John Bateman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec 1 1908 (Month) (Day) (Year)

7. AGE: 5 yrs. 6 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fred Bateman

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Banks.
(Address) Montpelier

15. Filed 5/25/1914 W. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 24 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1914, to May 24 1914 that I last saw him alive on May 24 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lues Hereditaria.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lud H Ashley M. D.
May 24 1914 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 6 mos. ..... ds. In the State 5 yrs. 6 mos. ..... ds.
Where was disease contracted, ...
If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier
DATE OF BURIAL: 5/26 1914

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52
County of Bear Lake. Primary Registration District No. 2136
City of Montpelier (No. ....., ... St.)
File No. 761
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velma Wallentine

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: August 13th 1901 (Month) (Day) (Year)

7. AGE: 12 yrs. 9 mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. C Wallentine

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary E. Payne

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. A Sparks
(Address) Dingle Idaho

15. Filed 5/4/1914 W. W Hedquist Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1914, to May 1914 that I last saw h[illegible] alive on May 2 1914 and that death occurred on the date stated above, at 12.30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Mitral Regurgitation & Heart

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Organic Heart Trouble

(Duration) 2 yrs. 5 mos. ..... ds.

(Signed) D. M Payne M. D.

5-4-1914 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 12 yrs. 9 mos. — ds. In the State 12 yrs. 9 mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dingle Idaho
DATE OF BURIAL: 5/5/1914

20. UNDERTAKER: None
ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier

Registration District No. 5 2
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 1864
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Trussell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Dec 29 1914
(Month) (Day) (Year)

7. AGE: ~~1~~ yrs. 5 mos. 17 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montpelier

10. NAME OF FATHER: Fred Trussell

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Rosa Hollandegger

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Trussell - Father
(Address) Montpelier Idaho

15. Filed 5/18/1914 H. N. Kinyon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 18 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Apl 20 1914
that I last saw h..... alive on Apl 20 1914
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Unknown
Marasmus

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Don Poyner M. D.
5-18 1914 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 5 mos. 17 ds. In the State ..... yrs. 5 mos. 17 ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier
DATE OF BURIAL: 5/20 1914

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: *(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 786
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)
Registration District No. 57
Primary Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Marguerite Messerly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widowed

6. DATE OF BIRTH: Jan 15th 1843 (Month) (Day) (Year)

7. AGE: 71 yrs. 5 mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Mahler

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rudolph Suetter
(Address) Montpelier

15. Filed 5/18 1914 W. W. Kingsford
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 16 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-9- 1914, to 5-16- 1914 that I last saw h[illegible] alive on 5-15- 1914 and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows: Unknown (Senile Decay)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Poyneer M. D.

5-17- 1914 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 16 yrs. — mos. ..... ds.
In the State 16 yrs. — mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Switzerland

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: 5/18 1914

20. UNDERTAKER: None ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7611
Registered No.

1. PLACE OF DEATH.
County of Bonneville
City of Moreopeles
Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs R Hack.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: March (Month) ..... (Day) 1881 (Year)

7. AGE: 33 yrs. 3 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Davis Co. Utah

10. NAME OF FATHER: Samuel W. Hack

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Martha Raymond

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred C. Evans
(Address): Raymond Ida

15. Filed 5/22/1914 H. H. King M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
By Lightning
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo. C. Ashby M. D.
May 22 1914 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State 33 yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wardboro
DATE OF BURIAL: 5/23/1914

20. UNDERTAKER: None
ADDRESS: —

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7867
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Princeton (No. ....., ... St.)

Registration District No. 66
Primary Registration District No. 2145.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Bunney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1883 (Year)

7. AGE: 30 yrs. 8 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Frank Bartlett

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: — Kramer

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Bunney
(Address) Princeton Idaho

15.
Filed May 27 1914
Dr. J. W. Monfort
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1913, to May 27 1914
that I last saw her alive on May 26 1914
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

General Tuberculosis

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Monfort M. D.
May 28 1914 (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mendenhall County
DATE OF BURIAL: May 28 1914

20. UNDERTAKER: E Anderson
ADDRESS: Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 756

1. PLACE OF DEATH.
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorthy Jane Utz

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	

6. DATE OF BIRTH: 5 (Month) 8 (Day) 1913 (Year)

7. AGE: 1 yrs. ..... mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Latah Idaho

10. NAME OF FATHER: Col Utz

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Anna Somerweek

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Col Utz
(Address) Palouse Idaho

15. Filed May 9 1914 — D. J. Thompson, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1914, to May 9 1914 that I last saw her alive on 7 of May 1914 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

..... (Duration) ..... yrs. 1 mos. 2 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos S LeBard M. D.
5-7 1914 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Potlatch Ida — DATE OF BURIAL: May 9 1914

20. UNDERTAKER: E Anderson — ADDRESS: Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7868

Name Dorthy Ione Utz

Date of Death May 8, 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) Jos S. Le Pard M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7869
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Princeton
Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Rosar

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH August 9 1832
(Month) (Day) (Year)

7. AGE 81 yrs. 8 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER. Ben Rosar

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Laura Lowd

13. BIRTHPLACE OF MOTHER (State or Country) do Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... (Address) .....

15.
Filed June 1st 1914 D. J. N. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May. 31 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May. 26th 1914, to May. 29th 1914
that I last saw him alive on May. 29th 1914
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Chronic Prostatitis
..... (Duration) 10 yrs. ..... mos. ..... ds.
Contributory (Secondary) Cystitis
..... (Duration) 5 yrs. ..... mos. ..... ds.
(Signed) J. N. Thompson M. D.
June 1 1914 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Gold Creek — DATE OF BURIAL June 1 1914

20. UNDERTAKER C. L. Sloan — ADDRESS Potlatch Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Drumeau
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 44
Primary Registration District No. 2121
(No. ——, ——— St.)

File No. 71
Registered No. 9
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Byron Luther Jones

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 18th (Day), 1914 (Year)

7. AGE: 0 yrs. 0 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Drumeau Idaho

10. NAME OF FATHER: George Riley Jones

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Blanche Slattery

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 6/6 1914 J. C. Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 31st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1914; to May 31 1914
that I last saw him alive on May 31 1914
and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ✓ yrs. ✓ mos. 14 ds.

Contributory (Secondary) —
(Duration) ✓ yrs. ✓ mos. 14 ds.

(Signed) J. C. Bartlett M. D.
6/6 1914 (Address) Drumeau Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Drumeau Idaho
DATE OF BURIAL: 6/1 1914

20. UNDERTAKER: J. L. Benham
ADDRESS: Drumeau Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 1787
Registered No. 11

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Bagley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
May (Month) 2 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ~~4~~ hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Samuel Bagley

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Berna Hill

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Bagley
(Address) Aberdeen Ida.

15.
Filed May 2 1914 Mcnee Kinna
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No physician in attendance
I am satisfied death was due to
Weakness + Marasmus
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr. C. Mackinnon M. D.
May 2 1914 (Address) Aberdeen Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Yuma Cemetery	May 3 1914
20. UNDERTAKER	**ADDRESS**
Samuel Bagley	Aberdeen Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 116

Primary Registration District No. 2195

File No. 1454

Registered No. 12

County of Bingham

City of Aberdeen (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Marcellus Harris

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH: Oct (Month) 24 (Day) 1846 (Year)

7. AGE: 67 yrs. 6 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Cunelius B. Harris

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: ——— Ritchie

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peyton R Harris
(Address) Aberdeen Ida

15. Filed May 13 1914 M. McCutchinson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 20 1914 to May 12 1914 that I last saw him alive on May 11 1914 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(Duration) ..... yrs. 3 mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. McCutchinson M. D.

May 13 1914 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mennonite Cemetery — DATE OF BURIAL: May 14 1914

20. UNDERTAKER: Acting Peyton R Harris — ADDRESS: Aberdeen Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2193
File No. 17873
Registered No. 13

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Eddyrean Lewthwaite
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Single

6. DATE OF BIRTH
April (Month) 1 (Day) 1914 (Year)

7. AGE
..... yrs. 1 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE
(State or Country) Idaho.

10. NAME OF FATHER Robert N. Lewthwaite

11. BIRTHPLACE OF FATHER
(State or Country) England.

12. MAIDEN NAME OF MOTHER Elizabeth Edyrean

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R N. Lewthwaite
(Address) Aberdeen Ida

15.
Filed May 13 191 4 M C Martinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1914, to May 12 1914
that I last saw h[illegible] alive on May 11 1914
and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Hydrocephalus (Acute)

..... (Duration) ..... yrs. ..... mos. 4 ds.
Contributory
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M C Martinn M. D.
May 13 1914 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mennonite Cemetery — DATE OF BURIAL May 13 1914

20. UNDERTAKER R N Lewthwaite — ADDRESS Aberdeen Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 116

County of Bingham

Primary Registration District No. 2195

File No. 787

City of Aberdeen (No. ....., ... St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Bartel

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Married

6. DATE OF BIRTH: Nov (Month) 30 (Day) 1866 (Year)

7. AGE: 47 yrs. 5 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Hermann Sudermann

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Elizabeth Edyer

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Will Bartel
(Address): Aberdeen Ida

15. Filed May 10 1914 Mrs. M. Kinnin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1912, to May 9 1914, that I last saw h[illegible] alive on May 8 1914 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(Duration) 10 yrs. - mos. ds.

Contributory (Secondary) Ascites

(Duration) 2 yrs. mos. ds.

(Signed) Dr. C. McKinnon M. D.

May 10 1914 (Address) Aberdeen Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery | DATE OF BURIAL: May 11 1914

20. UNDERTAKER: W. W. Bartel | ADDRESS: Aberdeen Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Aberdeen

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 1763

Registered No. 135

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barbara Frey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: (Month) (Day) 1862 (Year)

7. AGE: 52 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: John Becker

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Mary Houpt

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jake F. Frey

(Address) Aberdeen, Idaho.

15.

Filed May 30 1914 McMackin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1914, to May 27 1914, that I last saw h[illegible] alive on May 28 1914, and that death occurred on the date stated above, at " M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Stomach.

(Duration) — yrs. 6 mos. — ds.

Contributory (Secondary) acute endocarditis

(Duration) — yrs. 3 mos. — ds.

(Signed) John B. Cooper M. D.

19 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: German Congregational Cemetery, Aberdeen — DATE OF BURIAL: May 31 1914

20. UNDERTAKER: Jake F. Frey — ADDRESS: Aberdeen.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ..... St.)

File No. 7471
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Filer Ida
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sidney Ward Blystone
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 16 (Day) 1904 (Year)

7. AGE: 10 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Colo

10. NAME OF FATHER O. L. Blystone

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Jessie Crick

13. BIRTHPLACE OF MOTHER (State or Country) Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. L. Blystone
(Address) .....

15. Filed 5/11 1914 A. A. Newberry Local Registrar
By W. Tuldge Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1914, to May 9 1914, that I last saw him alive on May 9 1914, and that death occured on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Measles
.....
.....
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 7 ds.
(Signed) J. V. Humphrey M. D.
5/11 1914 (Address) Buhl

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Ida
DATE OF BURIAL: 5/11 1914

20. UNDERTAKER: C. J. Crosby
ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of Filer Ida

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

File No. 4544

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Percy Leonard Blystone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March 26 (Month) (Day) 1905 (Year)

7. AGE: 9 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Colo

10. NAME OF FATHER O L. Blystone

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Bessie Price

13. BIRTHPLACE OF MOTHER (State or Country) Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. L. Blystone

(Address) .....

15. Filed 5/14 1914

A. W. Newberry
Local Registrar
By M. Tubbs

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1914, to May 9 1914, that I last saw h[illegible] alive on May 9 1914, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. 2 ds.

(Signed) J. Dungan M. D.

(Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Ida

DATE OF BURIAL: 5/11 1914

20. UNDERTAKER: C J Croby

ADDRESS: Filer Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6274
Primary Registration District No.
(No. ....., ... St.)

File No. 7879
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dennis Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
male	white	(Write word.) single

6. DATE OF BIRTH
Unknown
(Month) (Day) (Year)

7. AGE
75 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work retired farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. Donora
(Address) Genesee Ida.

15.
Filed May 21 1914 W. H. Ehren
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 19 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to May 18 1914 that I last saw h[illegible]ive on May 18 1914 and that death occurred on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
(Duration) 6 mos. ds.
Contributory (Secondary) Cerebral Embolism Sudden
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Thorne M. D.
May 19 1914 (Address) Genesee Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cath. Cem. | DATE OF BURIAL May 22 1914

20. UNDERTAKER J. C. Lambert | ADDRESS Genesee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & PUBS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of [illegible]
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 101
(No. ....., ... St.)

File No. 7-5
Registered No. 40
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Florence Olmsted

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Fm	White	Single

6. DATE OF BIRTH
May (Month) 27 (Day) 1868 (Year)

7. AGE
45 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Teacher
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER Lewis Olmsted

11. BIRTHPLACE OF FATHER
(State or Country) Connecticut

12. MAIDEN NAME OF MOTHER Christina Fraser

13. BIRTHPLACE OF MOTHER
(State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Dan. Gerlough
(Address) 507 Ash Street Moscow

15.
Filed May 27 1914 J. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 26" (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 A.M. May 26 1914, to 11 A.M. May 26 1914, that I last saw her alive on May 26" 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Unknown to me.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Carithers M. D.
19 ..... (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hellsburg Ore	5/29 1914

20. UNDERTAKER	ADDRESS
Geo Stella	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 7881
Registered No. 36
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Grace Mornington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F. W.	W.	Widow

6. DATE OF BIRTH
Sept (Month) 16 (Day) 1847 (Year)

7. AGE
66 yrs. 9 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER R Edwards

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Mornington
(Address) Moscow

15.
Filed May 12 1914 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend her 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
valvular heart disease
(Having examined her some time ago)
(Duration) Days yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Clarke M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moscow — DATE OF BURIAL May 13 1914

20. UNDERTAKER Geo Kelly — ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 7882
Registered No. 35

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry F. Batey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH: April (Month) 24 (Day) 1856 (Year)

7. AGE: 58 yrs. — mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Peoria Ill.

10. NAME OF FATHER: William H. Batey

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: M. E. Miller.

13. BIRTHPLACE OF MOTHER (State or Country): St. Louis Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. W. Lee
(Address) Moscow Idaho

15.
Filed May 23 191 — Dft Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1914, to May 22 1914, that I last saw him alive on May 22 1914, and that death occurred on the date stated above, at 11-P M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.
May 23 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 5/24 1914

20. UNDERTAKER: Leo Stoltz — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1014
File No. 7883
Registered No. 39

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ned Eastbrook
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 31 (Day) 1862 (Year)

7. AGE: 51 yrs. 7 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: labor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Charley Eastbrook

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Leigh
(Address) Sprague

15. Filed May 25 1914 S. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sawhorn office 191..., to death May 23 1914, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Electrocuted accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. F. Rae M. D.
19..... (Address) Moscow Head Office

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sprague Wn | DATE OF BURIAL: 5/26 1914

20. UNDERTAKER: Geo Stelly | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 7844
Registered No. 38

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward August Kresterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: March 17 1891 (Month) (Day) (Year)

7. AGE: 23 yrs. 2 mos. 2 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: August Kresterson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Emma Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Auvid Kresterson
(Address) Moscow Ida.

15. Filed May 26 1914 S. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 1913, to May 9 1914, that I last saw h[illegible] alive on May 9 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary abcess

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Tuberculosis - I think

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas L. Gritman M. D.

5/25 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 5/26 1914

20. UNDERTAKER: Geo Stelly — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

#5

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
(No. [redacted] Hazel St.)

File No. 7[illegible]
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME [redacted] Headrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1914 (Year)

7. AGE: ——yrs. 4 mos. 10 ds.
IF LESS than 1 day how many .....*hrs. or* .....*mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work ——
(b) General nature of industry business, or dstablishment in which employed (or employer) ——

9. BIRTHPLACE (State or Country) Moscow

10. NAME OF FATHER James Headrick

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Katie Goss.

13. BIRTHPLACE OF MOTHER (State or Country) ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Headrick
(Address) Moscow Ida

15. Filed May 20 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 20" (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20" 1914, to May 20" 1914, that I last saw her alive on March 1" 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Probably Pneumonia following Measles.

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) Measles
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) W. H. Carruthers M. D.
5/20 1914 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burcau Cem. DATE OF BURIAL: 7/20 1914

20. UNDERTAKER: Leo Stolz ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Bonner, Primary Registration District No. 215-6

File No. 7886

City of Bonners Ferry Ida (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME D .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: April (Month) 9th (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bonners Ferry Ida

10. NAME OF FATHER Dan Lawrence

11. BIRTHPLACE OF FATHER (State or Country) Mich

12. MAIDEN NAME OF MOTHER Mable Hider

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lawrence

(Address) Bonners Ferry Ida

15. Filed April 9th 1914. E E Inc. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6th 1914, to April 9th 1914, that I last saw h[illegible] alive on April 9th 1914, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Failure of the foramen ovale of the heart to close.

..... (Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Inc. M. D.

April 9 1914 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: April 12 1914

20. UNDERTAKER: John J. Moser — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7887
Registered No.

1. PLACE OF DEATH.
County of Bonner
City of Bonners Ferry (No. ....., St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 2156.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sam Flatten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: ~~##~~ February 24 (Month) (Day) 1861 (Year)

7. AGE: 53 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Truck Walker
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tonset Norway

10. NAME OF FATHER: Otter Flotten

11. BIRTHPLACE OF FATHER (State or Country): Tonset Norway

12. MAIDEN NAME OF MOTHER: Sarah Moen

13. BIRTHPLACE OF MOTHER (State or Country): Tonset Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Sam Anderson
(Address) Baldenville Wisconsin

15. Filed Apr. 19th 1914 E. Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at .....

The CAUSE OF DEATH* was as follows:
Injuries to chest
(Struck by train)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. Fry M. D.
4/12 1914 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida
DATE OF BURIAL: 4/17 1914

20. UNDERTAKER: John J. Moore
ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner — Registration District No. 79.
City of Bonners Ferry Id. — Primary Registration District No. 215b.
If death occurs away from usual residence, give facts called for under special information. — No. ____ St.)

File No. 7888
Registered No. ____
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME. Isabelle Bell Owen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH — July (Month) 30 (Day) 1851 (Year)

7. AGE — 62 yrs. 8 mos. 27 ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmers Wife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Hatfield

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Isabelle Hatfield

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Owen
(Address) Bonners Ferry Ida

15. Filed Apr. 28 1914. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH — April (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 13th 1914, to Apr. 27 - 1914, that I last saw her alive on Apr. 27 - 1914, and that death occurred on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage (apoplexy)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
4/28 1914 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — Bonners Ferry Ida — DATE OF BURIAL 4/29 1914

20. UNDERTAKER — C. L. Moore — ADDRESS Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 2156

File No. 7886

County of .....

City of ..... (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrac Ohanahsis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH ..... (Month) ..... (Day) 18?? (Year)

7. AGE: 35 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Armenia

10. NAME OF FATHER: Ohanahsis

11. BIRTHPLACE OF FATHER (State or Country): Armenia

12. MAIDEN NAME OF MOTHER: Laito

13. BIRTHPLACE OF MOTHER (State or Country): Armenia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mordecai Portamian

(Address) Bonners Ferry Ida

15.

Filed May 8th 1914 E Fahy. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6-1914 to May 7th 1914, that I last saw h[illegible] alive on May 7- 1914 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

gunshot wound of chest and stomach (homicide)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E Fahy M. D.

5/8/1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida | DATE OF BURIAL: 9 1914

20. UNDERTAKER: C. T. Mason | ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 215-6
File No. 7511
Registered No.

1. PLACE OF DEATH.
County of Bonner
City of Post Hill (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George English

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: August 27th 1887 (Month) (Day) (Year)

7. AGE: 26 yrs. 6 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Dan English

11. BIRTHPLACE OF FATHER (State or Country): New Brunswick

12. MAIDEN NAME OF MOTHER: Elizabeth Cassidy

13. BIRTHPLACE OF MOTHER (State or Country): New Brunswick

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel English
(Address) Creston B.C.

15. Filed May 20th 1914. E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 19th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Fracture of skull
(accidental fall from a cliff)
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry, M. D.
5/20/1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Post Hill Ida | DATE OF BURIAL: 5/22 1914

20. UNDERTAKER: J. T. Moore | ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

McCrackin

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 12 7891

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wardner (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2101

2. FULL NAME Elvira Ellen Goldsmith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Mar 26 1884 (Month) (Day) (Year)

7. AGE: 30 yrs. — mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo. S. Akire

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Anna Cully

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Goldsmith
(Address) Wardner Idaho

15. Filed May 15 1914 Geo S Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 11 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4th 1914, to April 10th 1914 that I last saw her alive on April 10 1914, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:
Acute Heart Failure.
Valvular Heart Disease
Mitral Regurgitation
(Duration) — yrs. 2 mos. 7 ds.
Contributory (Secondary) Pregnancy - Confinement Feb 4, 1914
(Duration) yrs. mos. ds.
(Signed) Alexander H. McCrackin M. D.
Apr 11 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wardner Ida. | DATE OF BURIAL: 4/14 1914

20. UNDERTAKER: Ironhill | ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 7201
(No. ....., ... St.)

File No. 10 7202
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Truman Lamb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 22 (Day) 1858 (Year)

7. AGE: 30 yrs. 5 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Henry Lamb

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Philena Brinkerhoff

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leslie Lamb
(Address) Kellogg Ida.

15. Filed May 30 1914 Geo S Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1914, to March 3 1914
that I last saw him alive on March 3 1914,
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Multiple fractures of skull

(Duration) — yrs. — mos. 6 ds.
Contributory (Secondary) Meningitis from fractures
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Alexander D. McEachin M. D.
March 11 1914 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 6 ds. In the State 20 yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Wardner, Idaho

19. PLACE OF BURIAL OR REMOVAL: Greenwood - Kellogg
DATE OF BURIAL: March 6th 1914

20. UNDERTAKER: E B Trumbull
ADDRESS: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 123

County of Shoshone

Primary Registration District No. 2201

City of Burnaville Camp (No. ..... St.)

File No. 11

Registered No. 1893

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ben Leahy

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	single

6. DATE OF BIRTH

Do not know (Month) (Day) 1864 (Year)

7. AGE

50 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Miner

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed May 7th 1914 Geo. S Lesher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hypostasis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. C. Bodley M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Cyteau	May 7 1914

20. UNDERTAKER	ADDRESS
E. B. Mourhill	Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

County of Gooding Primary Registration District No. File No. 785

City of Wendell (No. , St.) Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Dorothy Reimers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. 26 1903 (Month) (Day) (Year)

7. AGE: 10 yrs. 6 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Pupil.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: H. Emil Reimers

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Celia Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed May 20 1914 H E Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March. 28 191[illegible] (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased fr[illegible] Mch. 24 1914, to Mch. 28 191[illegible] that I last saw h[illegible] alive on Mch. 28 191[illegible] and that death occurred on the date stated above, at 6 a[illegible]

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) — yrs. — mos. 4 ds.

Contributory (Secondary): Appendicular Abscess

(Duration) — yrs. — mos. — ds.

(Signed) J. P. Tibbutson M. D.

Mch 31 1914 (Address) Wendell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Wendell

DATE OF BURIAL: Mch 29 1914

20. UNDERTAKER: ×

ADDRESS: ×

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 72
Primary Registration District No. 2120
(No. ....., ... St.)

File No. 789
Registered No. 60
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ora Pugsmire

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	Wid

6. DATE OF BIRTH
January (Month) 8 (Day) 1914 (Year)

7. AGE
X yrs. 4 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ammon, Ida

10. NAME OF FATHER A. T. Pugsmire

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Minnie Ward

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. T. Pugsmire
(Address) Ozone, Ida

15.
Filed June 3 1914 E. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 30 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h... alive on ——— 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

No Medical Attendance

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Hansen M. D.
6/3 1914 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon Ida. DATE OF BURIAL: 5/31 1914

20. UNDERTAKER: E. E. Dunwoody ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 72
Primary Registration District No. 2170
(No. ..... St.)

File No. 749
Registered No. 59
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora Pengmire

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH: January (Month) 8 (Day) 1914 (Year)

7. AGE: X yrs. 4 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Ammon

10. NAME OF FATHER A. J. Pengmire

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Minnie Ward

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo Nielsen
(Address) Ammon Ida

15. Filed Jan 3 1917 C. Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows:

Do Medical Attendance

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. Hammond M. D.
6/3 1917 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Ammon | DATE OF BURIAL: 5/25 1914

20. UNDERTAKER: C. E. Dimmoody | ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 2130
(No. ....., ... St.)

File No. 789
Registered No. 57

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmund Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
Dec (Month) 25 (Day) 1863 (Year)

7. AGE
50 yrs. 1 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idoho

10. NAME OF FATHER Edmond Nelson

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Ann Peterseen

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. S. Nelson
(Address) Ida Falls

15.
Filed June 3 1914 E. Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 31- (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found dead in bed near Idaho Falls
Cause unknown
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Mosley Coroner
6/3 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	6/3 1914

20. UNDERTAKER	ADDRESS
E. E. Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneville

Primary Registration District No. 21-0

City of Idaho Falls (No. ....., ... St.)

File No. 789

Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Muhleman

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	American	

6. DATE OF BIRTH: May (Month) 29 (Day) 1914 (Year)

7. AGE: ✓ yrs. ✓ mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Thos. W. Muhleman

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Reeves

13. BIRTHPLACE OF MOTHER (State or Country) New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos. W. Muhleman
(Address) Idaho Falls

15. Filed June 1 1914 C. H. Hunsaker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1914, to May 29 1914, that I last saw h[illegible] alive on May 29 1914, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows: Hemiplegia with 6 mos.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Hunsaker M. D.

May 31 1914 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Lawn | DATE OF BURIAL: June 1st 1914

20. UNDERTAKER: Thos. W. Muhleman | ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
File No. 791
Registered No. 55

1. PLACE OF DEATH.,
County of Bonneville
City of Idaho Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME [illegible]

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH: May (Month) 27 (Day) 1914 (Year)

7. AGE: [illegible] yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Earl George Rupp

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake City

12. MAIDEN NAME OF MOTHER Ruby Baker

13. BIRTHPLACE OF MOTHER (State or Country) Star Valley Wyo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl G Rupp
(Address) Black Foot R.F.D. #1

15. Filed May 29 1914 Ed Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1914, to ..... 191..., that I last saw her alive on May 27 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Premature 6 mo.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A R Soderquist M. D.
5/27 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rose Lawn Idaho	May 29 1914
20. UNDERTAKER	ADDRESS
Thos. W. Mulhern	Idaho Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21
File No. 7011
Registered No. 5-4

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. Bassett St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nathan G Childs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: July (Month) 30 (Day) 1871 (Year)

7. AGE: 17 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Office Work
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Nathan Childs

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annie E. Wadsworth

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Loren Jensen
(Address) Idaho

15.
Filed May 29 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1914, to May 27 1914, that I last saw him alive on May 27 1914, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Diabetis

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) G. H. Coulthard M. D.
5/29 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Taylorville Cemetery — DATE OF BURIAL: 5/29 1914

20. UNDERTAKER: C E Dinwoodey — ADDRESS: Ida Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2140
(No. ....., ... St.),

File No. 7903
Registered No. 1-2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
May (Month) 5 (Day) 1838 (Year)

7. AGE
76 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Christ Christensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Holland

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E M. Schlademan
(Address) Idaho Falls Ida.

15.
Filed May 18 1914
J E Emmett
Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1914, to May 16 1914, that I last saw h.... alive on May 13 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Drowning as Casual
Accidental drowning
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H S Fuller M. D.
5/16 1914 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill
DATE OF BURIAL: May 19 1914

20. UNDERTAKER: T. W. Muhleman
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 790
Registered No. 5-0

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Barden
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: July (Month) 19 (Day) 1913 (Year)

7. AGE: ..... yrs. 10 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Jno. L. Barden

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Almeda Waters

13. BIRTHPLACE OF MOTHER (State or Country): Provo. Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jabez Waters
(Address) .....

15. Filed May 16 1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1914, to May 16 1914, that I last saw him alive on May 16 1914 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
(a) Erysipelas
.....
.....
..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John McCollom M. D.
5/16 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Iona Ida — DATE OF BURIAL: 5/18 1914

20. UNDERTAKER: C. E. Linwood — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 73
County of Bonneville Primary Registration District No. 2110
City of Ucon (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 7911
Registered No. 49
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Heber Andrus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH Sep (Month) 20 (Day) 1869 (Year)

7. AGE 45 yrs. 7 mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Milo Andrus

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Jane Munday

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt. Andrus
(Address) Ucon

15. Filed May 13 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1914 to May 9 1914, that I last saw h[illegible] alive on May 7 1914 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the heart,

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Pleurisy La Grippe

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray W. Fisher, M. D.

May 10 1914 (Address) Ucon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ucon Ida	5/13 1914

20. UNDERTAKER	ADDRESS
C. E. Dinwoodey	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 7911
Registered No. 40

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mikeals Owen Brown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Feb (Month) 5 (Day) 1893 (Year)

7. AGE
21 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Rider
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Kansas

10. NAME OF FATHER
Wm F. Brown

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER
Peters

13. BIRTHPLACE OF MOTHER
(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Linzy Brown
(Address) Dillon Montana

15.
Filed May 11 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1914, to May 9 1914, that I last saw him alive on May 9 1914, and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchus

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
May 11 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls — DATE OF BURIAL: May 13 1914

20. UNDERTAKER: J. M. Mathewson — ADDRESS: Idaho Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to the registrar of Vital Statistics)

Death Certificate No. 7907

Name Ulisitis Owen Brown

Date of Death May 9, 1914.

Cause of Death Broncho Pneumonia

Contributary Cause of death

(Sign here) C. M. Cline M.D.
By A. R. Sodequist

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 790-
Registered No. [illegible]47

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 2130

2. FULL NAME Laura Layne

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Sept (Month) 21 (Day) 1894 (Year)

7. AGE: 19 yrs. 6 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chris Poulson

11. BIRTHPLACE OF FATHER (State or Country): Holstebro Denmark

12. MAIDEN NAME OF MOTHER: Anna Allen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy Pendleton
(Address) Idaho Falls

15. Filed May 11 1914 J. E. Emmett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1914 to May 9 1914, that I last saw her alive on May 9 1914 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis of six days duration
Bronchitis with probably Pulmonary tuberculosis (Duration) yrs. mos. ds.
Contributory (Secondary) Bronchitis of toxic nature
(Duration) yrs. 1 mos. — ds.
(Signed) G. W. Pendleton M. D.
May 11 1914 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 1 1/4 mos. ... days. In the State. 19 yrs. 6 mos. 28 days.
Where was disease contracted if not at place of death?
Former or usual residence Idaho Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: May 11 1914

20. UNDERTAKER: C. N. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7909

Registered No. 46

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneville

Primary Registration District No. 2170

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jonathan Davies

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

78 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Liverpool Eng.

10. NAME OF FATHER Jonathan Davies

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Morant Grace

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Davies Jr

(Address) Idaho Falls,

15.

Filed May 7 1914 E. Emmett Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10th 1914, to April 6th 1914, that I last saw h[illegible] alive on April 6 1914 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas C. Wilson M. D.

May 9 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelton Ida	May 10 1914

20. UNDERTAKER	ADDRESS
G. W. Muhleman	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2150
(No. ....., ... St.)

File No. 7910
Registered No. 45

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank K Hitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
May (Month) 2 (Day) 1868 (Year)

7. AGE
46 yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer & Stockman
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER J A Hitt

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Phebe Mann

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F K Hitt
(Address) Twin Falls Idaho

15.
Filed May 5 1914 E E Dunnet Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1912 to May 4 1914, that I last saw him alive on May 4 1914, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Cerebral thrombosis and embolism

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) Was subject to attacks of acute pleurisy
Intervals (Duration) 20 yrs. — mos. — ds.

(Signed) G. W Pendleton M. D.
5/1 1917 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 26 yrs. ..... mos. ..... days. In the State 26 yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Idaho Falls Idaho
Former or usual residence Idaho Twin Falls Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	May 5 1914

20. UNDERTAKER	ADDRESS
C. W. McClenahan	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls, (No. ....., ... St.)
Registration District No. 73
Primary Registration District No. 2100
File No. 791
Registered No. 44
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willie Elizabeth Blazier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Jan 5 1872 (Month) (Day) (Year)
7. AGE: 42 yrs. 4 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Mississippi
10. NAME OF FATHER: Robinson
11. BIRTHPLACE OF FATHER (State or Country): Miss.
12. MAIDEN NAME OF MOTHER: ~
13. BIRTHPLACE OF MOTHER (State or Country): ~
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Melissa Hayward
(Address) Downey Idaho
15.
Filed May 2 1914 J. E. Nicholls Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 2nd 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apl 28 1914, to May 1st 1914, that I last saw h[er] alive on May 1st 1914, and that death occurred on the date stated above, at 9 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia, Lobar.
3 Days
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. M. Hickes M. D.
19 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: May 4 1914
20. UNDERTAKER: J. W. Muhleman — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2183
(No. Fuller Hospital St.)

File No. 7912
Registered No. 73

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Obidiah Armstrong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 9 (Day) 1858 (Year)

7. AGE: 56 yrs. 1 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Wm Armstrong

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Kirk

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. O. Armstrong
(Address) Rigby Ida.

15.
Filed Apr 31 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April ~~27~~ (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 20 1914, to Apr 27 1914,
that I last saw h[im] alive on Apr. 27 1914,
and that death occurred on the date stated above, at 8-30 P M.

The CAUSE OF DEATH* was as follows:

Hepatic Abscess.
Hepatitis.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray S Hinkins M. D.
Apr 27 1914 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby - Idaho
DATE OF BURIAL: 5/2 1914

20. UNDERTAKER: C E Dimmoodey
ADDRESS: Ida Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 215-0
File No. 7913
Registered No. 42

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Edna Stepp

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH: Apr (Month) 10 (Day) 1914 (Year)

7. AGE: x yrs. x mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls, Ida

10. NAME OF FATHER: Steve C. Stepp

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Blanche Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Steve C. Stepp
(Address): Idaho Falls, Ida

15. Filed Apr 27 1914 C. G. Dimmock Local Registrar
Dep.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 10 1914, to Apr. 29, 1914 that I last saw her alive on Apr. 28, 1914 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Septicaemia

(Duration) ... yrs. ... mos. 18 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. V. Mellen M. D.
4/27 1914 (Address) Idaho Falls,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 4/30 1914

20. UNDERTAKER: C. G. Dimmock — ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7914

Registered No. 41

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2110
(No. , St.)

2. FULL NAME Neils Adolphson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Feb. 1. 1911 (Month) (Day) (Year)

7. AGE: 3 yrs. 2 mos. 25 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: -
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Jacob S. Adolphson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Kristina Franzen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob S Adolphson
(Address)

15. Filed 4/28 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 25 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 23 1914, to April 25 1914, that I last saw him alive on Apr. 25 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) yrs. 6 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. W. Sydenstricker M. D.
4/27 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Next Sweden — DATE OF BURIAL: Apr 27 1914

20. UNDERTAKER: F. W. Muhlestein — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2110

File No. 791
Registered No. 40

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Westergard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
April (Month) 24 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many 3 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Westergard

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Chadburn

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Westergard
(Address) Idaho Falls

15.
Filed Apr 25 1914 H. E. Barnett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1914 to April 25 1914 that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Still Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Fuller M. D.
4/21 1914 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Grant Cem — DATE OF BURIAL: April 26 1914

20. UNDERTAKER: G. W. Hunt — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7916
Registered No. 39

1. PLACE OF DEATH.
Registration District No. 73
Primary Registration District No. 2150
County of Bonneville
City of Idaho Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Louisa Josephens Engstrom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 31st 1879 (Month) (Day) (Year)

7. AGE: 37 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Elon

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Christina Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Victor Engstrom
(Address) Idaho Falls. Route 3.

15.
Filed Apr 24 1914 J E Bennett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1914, to Apr. 21 1914, that I last saw h[illegible] alive on Apr. 21 1914 and that death occurred on the date stated above, at 0 2 0 M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. P. Dodenzeiat M. D.
4/21 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Cemetary — DATE OF BURIAL: Apr 26 1914

20. UNDERTAKER: Sinwoody Furn Co. — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

County of Bonneville

Primary Registration District No. 2150

City of Idaho Falls

(No. ....., ... St.)

File No. 791

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mc Gann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Apr. (Month) 9 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bonneville Co Ida.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Kathrine McGann

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kathrine Mc Gann
(Address) Ida Falls Ida

15. Filed Apr 24 1914 J E Bennett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9 1914, to Apr. 15 1914, that I last saw her alive on Apr. 15 1914, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. R. Sobenmix M. D.

4/23 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho | DATE OF BURIAL: Apr 24 1914

20. UNDERTAKER: Linwood Undertaking Co | ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7918
Registered No. 54

1. PLACE OF DEATH. Registration District No. 4
County of Adams Primary Registration District No. 2012
City of New Meadows (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Lathrop

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH: January (Month) 10 (Day) 1823 (Year)
7. AGE: 91 yrs. 2 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Kentucky
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Lathrop
(Address) Robinett Oregon
15.
Filed 5-21 1914 Frank E. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 7 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4/25/14 191..., to 4/7/14 191...
that I last saw her alive on 4/2/14 191...
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Senility.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Exhaustion
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. W. Whitmore M. D.
4-7- 1914 (Address) New Meadows Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Robinett Oregon — DATE OF BURIAL: 4-9 1914
20. UNDERTAKER: L. C. Northam — ADDRESS: Weiser Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Priest River
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 81
Primary Registration District No. 2158
(No. ....., ... St.)

File No. 791
Registered No. 6
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Herman Low.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	

6. DATE OF BIRTH: April (Month) 14 (Day) 1913 (Year)

7. AGE: 1 yrs. 1 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Priest River

10. NAME OF FATHER: Richard B. Low.

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Clara Yax

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Low
(Address) Priest River

15. Filed May 12 1914 E. D. McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11" (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 29 1914, to May 11 1914
that I last saw him alive on May 11" 1914,
and that death occurred on the date stated above, at 6 00 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia - Pneumo.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred'k M. Didier M. D.
May 11" 1914 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: May 11 1914

20. UNDERTAKER: None — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7919

Name Heiman Low

Date of Death May 11, 1914

Cause of Death Bronchopneumonia.

Contributary Cause of death Enteric involvement -tympanites.

(Sign here) Fredk W. Dreier M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Winchester (No. ....., ... St.)

Registration District No. 48
Primary Registration District No. 2127

File No. 115
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Johanna Hammerschl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: Feby 3 1858 (Month) (Day) (Year)
7. AGE: 56 yrs. 3 mos. ——— ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Austria
10. NAME OF FATHER: Stauder
11. BIRTHPLACE OF FATHER (State or Country): Austria
12. MAIDEN NAME OF MOTHER: I don't know [redacted]
13. BIRTHPLACE OF MOTHER (State or Country): Austria ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Hammerschl
(Address) Winchester, Ida
15.
Filed 5-4-1914 Elton A. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 3 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 18 1914, to May 3 1914
that I last saw her alive on May 2 1914
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Chronic Bright's Disease Dubreuils
aortic Stenosis
Erysipelas
(Duration) 4 yrs. ——— mos. ——— ds.
Contributory (Secondary) Erysipelas
(Duration) ——— yrs. ——— mos. one ds.
(Signed) Albert Lacey Klein M. D.
May 4 1914 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 5-5-1914
20. UNDERTAKER: none — ADDRESS: ———

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7921
Registered No. 8

1. PLACE OF DEATH.
County of Lewis
City of Winchester

Registration District No. 48
Primary Registration District No. 2127
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Lehman Walker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: January 10th 1913 (Month) (Day) (Year)

7. AGE: yrs. 10 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: F
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Winchester, Idaho

10. NAME OF FATHER: Jesse E. Walker

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Ida Lehman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J.E. Walker
(Address) Winchester

15.
Filed May 8 1914 Ellen B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 8th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5th 1914, to May 8th 1914
that I last saw him alive on May 7th 1914
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Uraemia Colitis

..... (Duration) ..... yrs. ..... mos. 1 5 ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellen B. Rogers M. D.
May 8 1914 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce
DATE OF BURIAL: May 9 1914

20. UNDERTAKER: none
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

[illegible] of [illegible]
[illegible] HEALTH
[illegible] Statistics

File No. 7922

1. PLACE OF DEATH.

County of Mandoka

City of Aeequia

Registration District No. 19

Primary Registration District No.

(No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick W Carney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Rancher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Ryan

(Address) Rupert

15. Filed May 25 1914

P. H. Scott
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.
Deceased did not have any medical attention.

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. H. Scott M. D.

19..... (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Butte Mont — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: W. J. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. , St.)

File No. 7923
Registered No. 96
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Finster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Do not know exact date (Month) (Day) 1837 (Year) of about

7. AGE: 77 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Do not know.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Do not know.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M McPherson
(Address) Salmon Idaho

15. Filed May 14 1914 Nellie L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 13th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10th 1914, to May 13 1914, that I last saw h~~im~~ alive on May 13 1914 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) F. S. Smyth M. D.
May 14 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Salmon Cemetery. DATE OF BURIAL: May 15th 1914

20. UNDERTAKER: W C Hoobler ADDRESS: Salmon

SYMS - YORK CO., PTRS. & BKRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

7924

1. PLACE OF DEATH.
County of Lemhi
City of Leadore
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ____, ____ St.)

File No. ____
Registered No. 38
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Colson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January 10th (Month) (Day) 1835 (Year)

7. AGE: 79 yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Andrew Allen Colson

11. BIRTHPLACE OF FATHER (State or Country): Do not know.

12. MAIDEN NAME OF MOTHER: Mary Shaeneck

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ella McCornick
(Address) Leadore Idaho

15. Filed May 20 1914 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 7" (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1914, to Apr 6 1914, that I last saw h was alive on Apr 8 12 AM 1914, and that death occurred on the date stated above, at 2 AM.

The CAUSE OF DEATH* was as follows:
Appendicitis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C L Powell M. D.
Apr 6 1914 (Address) Leadore Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Dubois Idaho
DATE OF BURIAL: May 10" 1914

20. UNDERTAKER: W M C Hobbler
ADDRESS: Jackson Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 792

1. PLACE OF DEATH:
County of Lemhi
City of Junction
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lily M. Purcell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 4 (Day) 1881 (Year)

7. AGE: 32 yrs. 3 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry Vreland

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Eliza Perry

13. BIRTHPLACE OF MOTHER (State or Country): Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mark Purcell
(Address) Leadore Idaho

15. Filed May 5 1914 — Hank A. Vance M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 15" 1914, to Mar. 16" 1914
that I last saw her alive on Mar. 15" 1914
and that death occurred on the date stated above, at 5304 M.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
Lost compensation hyem
about Dec. 1-1913
Probably (Duration) 24 yrs. — mos. — ds.

Contributory (Secondary) ..... (Duration) — yrs. — mos. ..... ds.

(Signed) C. B. Hatton M. D.
Mar. 18 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Junction Cemetery
DATE OF BURIAL: 3-18" 1914

20. UNDERTAKER: Gano
ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

May 20

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 792
Registered No. 414

1. PLACE OF DEATH.
County of Kootenai
City of Plummer

Registration District No. 14
Primary Registration District No. 2049
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Nora Harvey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept. (Month) 10 (Day) 1875 (Year)

7. AGE: 38 yrs. 8 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Sheldahl, Iowa.

10. NAME OF FATHER: George Harpel

11. BIRTHPLACE OF FATHER (State or Country): Ohio. not positive

12. MAIDEN NAME OF MOTHER: Minerva Vernon

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mahlon E Harvey
(Address) Plummer Ida

15. Filed May 29 1914 — J. D. Stewart, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1914, to May 28 1914
that I last saw h-r alive on May 22 1914
and that death occurred on the date stated above, at 9.20 a M.
The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A Nelson M. D.
5/23 1914 (Address) Tekoa Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Plummer, Ida. — DATE OF BURIAL: 5/26 1914

20. UNDERTAKER: W. L. Jaeger — ADDRESS: Plummer Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7929
Registered No. 413

1. PLACE OF DEATH. Registration District No. 12
County of Kootenai Primary Registration District No. 2057
City of Spirit Lake (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charles M Weston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 2 (Day) 1859 (Year)

7. AGE: 54 yrs. 7 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry business or establishment in which employed (or employer): Lumberman

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Weston
(Address) Spirit Lake Idaho

15. Filed 6/10 1914 S D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1914, to May 11 1914 that I last saw him alive on May 11 1914 and that death occurred on the date stated above, at 8:45 P M.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

..... (Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl D Prince M. D.

May 12 1914 (Address) Spirit Lake Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spirit Lake — DATE OF BURIAL: 5/13 1914

20. UNDERTAKER: H K Clapp — ADDRESS: Rathdrum

Exact statement of OCCUPATION is very important. See instructions on back of certificate. It may be printed in plain terms, so that it may be properly classified.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2051
File No. 793
Registered No. 412

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl J. Purcell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: June (Month) 28th (Day) 1912 (Year)

7. AGE: 4 yrs. 10 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rathdrum, Idaho.

10. NAME OF FATHER Frank F. Purcell

11. BIRTHPLACE OF FATHER (State or Country) Nebr.

12. MAIDEN NAME OF MOTHER Myrtle Harper

13. BIRTHPLACE OF MOTHER (State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank F. Purcell
(Address) Rathdrum, Ida.

15. Filed 6/10 1914 D.D. Brannon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1914, to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:
Drowning in Ditch

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Young M. D.
5/6 1914 - (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
On Hospital Property	May 6th 1914

20. UNDERTAKER ..... ADDRESS Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

7931

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

17

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Kootenai

Primary Registration District No. 2057

File No. 79

City of Parkinson (No. , St.)

Registered No. 411

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John G Pennington

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: July (Month) 6 (Day) 1835 (Year)

7. AGE: 79 yrs. 3 mos. 11 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Louis

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jay Pennington
(Address) Parkinson

15.
Filed 6/10 1914 J D Brennan Jr.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1914, to May 4 1914, that I last saw h alive on 4 1914, and that death occurred on the date stated above, at 4.0 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J D Brennan M. D.

5/5 1914 (Address) Parkinson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parkinson | DATE OF BURIAL: May 6 1914

20. UNDERTAKER: E Babb and Sons | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1932

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Post Falls

Registration District No. 12
Primary Registration District No. 2057
(No. ....., ... St.)

File No. 1932 4
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Rhodebeck.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): don't Know

6. DATE OF BIRTH: 70 yrs ago (Month) (Day) 1 (Year)

7. AGE: 71 yrs. ? mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: small ranch
(b) General nature of industry business or establishment in which employed (or employer): Civil War pensioner

9. BIRTHPLACE (State or Country): ?

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Klopfe
(Address) .....

15. Filed 4/20 1914 H D Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: about Apr 12th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Probable cause cerebral hemorrhage found dead in log cabin Apr 4 - evidently dead 8 days
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) about yrs. ..... mos. ..... ds.
(Signed) Earl D Brush M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mes ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bathdrum Idaho
DATE OF BURIAL: 4/6 1914

20. UNDERTAKER: Klopfe
ADDRESS: Bathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 6

Primary Registration District No. 20 11

File No. 1933

County of Adams

City of Fruitvale (No. ....., ... St.)

Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laurandine E. Carroll

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 26 1861 (Month) (Day) (Year)

7. AGE: 52 yrs. 7 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ino

10. NAME OF FATHER: Beatty Barton

11. BIRTHPLACE OF FATHER (State or Country): Ky ?

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J L B Carroll
(Address) Fruitvale Idaho

15.
Filed 6-19-1914 Frank E. Bown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 10 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1913, to March - 1914, that I last saw h[illegible] alive on March 29 1914, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Cloutier M. D.

6-12 1914 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Council — DATE OF BURIAL: May 13 1914

20. UNDERTAKER: Robert Young — ADDRESS: Council

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 20 11
File No. 1934
Registered No. 76

1. PLACE OF DEATH.
County of Adams
City of Council
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Henry Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 25 (Day) 1856 (Year)

7. AGE: 57 Yrs. 11 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Teaching Music (Retired)

9. BIRTHPLACE (State or Country) Connecticut

10. NAME OF FATHER Peter Anderson

11. BIRTHPLACE OF FATHER (State or Country) Wasa Finland

12. MAIDEN NAME OF MOTHER Francis F Pease

13. BIRTHPLACE OF MOTHER (State or Country) Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas. F. Anderson
(Address) Council

15. Filed 6-13-1914 Frank E Bowman Local Registrar

BYRNE - YORK CO., PTRS. & ENGS. 24688

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1914, to May 9 1914, that I last saw him alive on May 9 1914, and that death occured on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Watson M. D.

May 12 1914 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For ~~Hospitals, Institutions~~, Transients or ~~Recent Residents~~.)
At place of death ..... yrs. ..... mos. 6 days In the State 1 yrs. 1 mos. 14 days
Where was disease contracted if not at place of death? Indian Valley
Former or usual residence Boise Ida.

19. PLACE OF BURIAL OR REMOVAL: Council
DATE OF BURIAL: May 10 1914

20. UNDERTAKER: Robert Young
ADDRESS: Council

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
(No. ..... St.)

File No. 193
Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

2. FULL NAME Thos A. Dawson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single
6. DATE OF BIRTH. unknown (Month) (Day) 1 (Year)
7. AGE: 64 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): unknown
10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Thompson
(Address) Wallace Idaho
15. Filed May 19 1914 F. Leo Dingley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 21st 1914, to May 14th 1914, that I last saw him alive on May 14th 1914, and that death occured on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH* was as follows:
Ac. Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. 4 mos. ..... ds.
(Signed) Edward C. Thomson M. D.
5/19 1914 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: White Pine Montana — DATE OF BURIAL: 5/20 1914
20. UNDERTAKER: Wards Undertaking Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2331

Registered No. 37

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hosp. St.)
Registration District No. 20
Primary Registration District No. 1014
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard C Skillings

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 5 (Month) 15 (Day) 1924 (Year)

7. AGE ——Yrs. ——Mos. 8 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Idaho

10. NAME OF FATHER: Claude Skillings

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: S Rowe

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Claude Skillings
(Address) Burke Idaho

15. Filed May 23 1914 F Leo Tunder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1914. to May 23 1914. that I last saw h-im alive on May 23 1914 and that death occured on the date stated above, at 3:00 M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the Lungs -
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) None
(Duration) yrs. mos. ds.
(Signed) Drs Mowery M. D.
5/23 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida. DATE OF BURIAL: May 24 1914

20. UNDERTAKER: R D Worstell ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1911

File No. 193

Registered No. 134

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. H. Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 27 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Redruth England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Reed

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Lawrence

(Address) Kellogg Idaho

15. Filed May 8 1914 F Leo Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1914, to May 5 1914, that I last saw h[illegible] alive on May 5 1914 and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(Duration) Yrs. 0 mos. 0 ds.

Contributory (Secondary) Acute Colitis

(Duration) Yrs. 0 mos. 0 ds.

(Signed) W. H. Thompson M. D.

5/5 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida. DATE OF BURIAL: May 8 1914

20. UNDERTAKER: B. J. Forstell ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING.

SYMS - YORK CO., PTRS. & BOOKS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 393
Registered No. 43

1. PLACE OF DEATH.

County of
City of Wallace
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Baxter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. unknown
(Month) (Day) (Year)

7. AGE: Yrs. 33 Mos. ..... ds.
IF LESS than 1 day how many ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Pall Baxter

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) N Thompson Wardle & Co
(Address) Wallace

15. Filed May 10 1914 F Leo Langley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 7th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1914, to May 7th 1914, that I last saw h[illegible] alive on May 7th 1914 and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Peritonitis following
Traumatic Rupture of
Bowels

(Duration) Yrs. ..... mos. 13 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
5-9-14 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace DATE OF BURIAL: May 11 1914

20. UNDERTAKER: Ward Studebaker Co ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRS - YORK CO., PTRS. & ROBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 600
Primary Registration District No. 2178
(No. ..... St.)

File No. 1939
Registered No. 30

1. PLACE OF DEATH.
County of Madison
City of Y.F.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillie Mary Richman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 5 (Day) 1894 (Year)

7. AGE: 19 Yrs. 6 Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo. N. Richman

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Mary McKinley

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hazel Schofield
(Address) Teton City

15. Filed 6-5 191 4 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 3 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended* deceased from 5-28 191 4, to 6-3 191 4, that I last saw her alive on 6-5 191 4, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Typhoid.

(Duration) ..... Yrs. 0 mos. ..... ds.
Contributory (Secondary) Typhoid Scarlatina
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. Mansfield M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Teton City	6/6 1914
20. UNDERTAKER	ADDRESS
John Phillips	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

County of Madison — Primary Registration District No. 2178

City of Burton Ward (No. ..... St.) — May 31 1914

File No. 9940

Registered No. 129

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johanna C. Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 29 (Day) 1839 (Year)

7. AGE: 74 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Stary

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Lena Boglind

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Swenson
(Address) /

15. Filed 6-1 1914 — G. H. Esp — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-20 1914, to 5-31 1914, that I last saw her alive on 5-30 1914 and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia (acute)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. H. Esp M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 6/3 1914

20. UNDERTAKER: John Phillips — ADDRESS: Redburg

SYMS - YORK CO., PTRS. & ENGS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 1941
Registered No. 28
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Henry Straubs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Boy

6. DATE OF BIRTH: November (Month) 15 (Day) 1899 (Year)

7. AGE: 14 yrs. 6 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Boy
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF FATHER: Joseph Straubs

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Frohard Wahlen

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Straubs
(Address) Rexburg

15. Filed 5-28 1914 G. H. Eske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw him alive on May 10 191 4 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

General asthenia

(Duration) 14 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph ... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton
DATE OF BURIAL: 5/29 1914

20. UNDERTAKER: Rexburg
ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 A. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 102
Primary Registration District No. 2178
(No. ..... St.)

File No. 1942
Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Silas LaMar Jacobs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 31 (Day) 1912 (Year)

7. AGE: 1 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J Leo Jacobs.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Bertha M Clements

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J Leo Jacobs
(Address) .....

15. Filed 5-15 1914 G L Cook Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1914, to May 14 1914, that I last saw h[illegible] alive on May 14 1914, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Acute Gastro enteritis

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... Yrs. ..... mos. ..... ds.
(Signed) G L Cook M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 5-16 1914

20. UNDERTAKER: L M Williams. — ADDRESS: Rex.

BYRD - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

Primary Registration District No. 2119

File No. 1943

Registered No. 25

County of Franklin

City of Preston (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH: Jan. (Month) 11. (Day) 1864 (Year)

7. AGE: 50 yrs. 3 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife & Nurse
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Allen
(Address) Preston

15.
Filed June 4 1914 Dr Allen Kuster Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1914, to May 7 1914, that I last saw h.e.s. alive on May 6 1914, and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(Duration) — yrs. 2 mos. — ds.

Contributory (Secondary) Pneumonia

(Duration) — yrs. — mos. 10 ds.

(Signed) Geo States M. D.

May 8 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: May 9th 1914

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 1944
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME N. H. Lund

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: June (Month) 21st (Day) 1830 (Year)

7. AGE: 73 yrs. 11 mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hyrman L. Jensen
(Address) Preston Ida

15.
Filed June 9 1914 Dr. Allen Rutter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 31-st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 st 1914, to May 31 1914, that I last saw him alive on May 21 1914, and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Mitral Insufficiency
(Duration) 15 yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) H. H. Parkinson M. D.
19 ..... (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: May 1914

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1913
Registered No. 27

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Preston (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aldus Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 20 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Preston

10. NAME OF FATHER: Edward C Johnson

11. BIRTHPLACE OF FATHER (State or Country): Preston

12. MAIDEN NAME OF MOTHER: Pack

13. BIRTHPLACE OF MOTHER (State or Country): Nashville

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward C Johnson
(Address) Preston

15. Filed 2 2 1914 Dr Allen R Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1914, to May 22 1914 that I last saw him alive on May 22 1914 and that death occurred on the date stated above, at about 6 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Tuberculosis

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. ..... ds.

(Signed) Allen R Curtis M. D.
5/22 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho
DATE OF BURIAL: 5/22 1914

20. UNDERTAKER: Yorn
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7946
Registered No. 18

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Preston (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Baird Perkins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Mar (Month) 28 (Day) 1862 (Year)

7. AGE: 52 yrs. 2 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housekeeping duties
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lynn. Wabash Co Ind

10. NAME OF FATHER Robt. Baird.

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Jane Hadley

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lettie Long
(Address) Preston R.F.D. #1

15. Filed May 26 1914. D. Allen Clerk
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1913, to May 26 1914
that I last saw her alive on May 26 1914
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Multiple Carcinoma

(Duration) ..... yrs. Six mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. W. Stalker M. D.
May 28 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mapleton — DATE OF BURIAL: May 1914

20. UNDERTAKER: None — ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ....., ... St.)

File No. 91

Registered No. 29

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladace Perkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH

July (Month) 7th (Day) 1913 (Year)

7. AGE

..... yrs. 10 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Preston

10. NAME OF FATHER Grayson Perkins

11. BIRTHPLACE OF FATHER (State or Country) Caseville Ut.

12. MAIDEN NAME OF MOTHER Naomi Willcott Bell Alice Bennett

13. BIRTHPLACE OF MOTHER (State or Country) Preston

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Perkins

(Address) Preston

15.

Filed June 9 1914 Dr Allen Reeder Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 10 1914

May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1914, to May 10 1914 that I last saw her alive on May 8 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Mastoid Abscess

.....

.....

..... (Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) None

..... (Duration) — yrs. — mos. — ds.

(Signed) Dr D F Caufield M. D.

..... 19 ..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	May 12 1914

20. UNDERTAKER	ADDRESS
W. A. Skidmore	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1975D

7948

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7948

Registered No. 4

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Blaine
City of Fairfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2198
(No. ....., ... St.)

2. FULL NAME C. E. Gridley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 10 (Day) 1847 (Year)

7. AGE: 67 yrs. 2 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Del

10. NAME OF FATHER: G. W. Gridley

11. BIRTHPLACE OF FATHER (State or Country): U S A

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): U S A

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Gridley
(Address) Hagerman

15.
Filed June 20 1914 D. Ontiggs Local Registrar

MEDICAL CERTIFICATE OF DEATH

C. E. Gridley

16. DATE OF DEATH: June (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1914, to June 1 1914 that I last saw h alive on June 1 1914, and that death occurred on the date stated above, at 2 30 P M.

The CAUSE OF DEATH* was as follows:
Spotted fever

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) [illegible] M. D.
June 1 1914 (Address) Soldier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Odd Fellows Cemetery. Hagerman
DATE OF BURIAL: June 21 1914

20. UNDERTAKER: Mr Thompson
ADDRESS: Hagerman Idaho
J. E. Harris. Hailey.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Maynard
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 7017
Registered No. 7
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Marion R Nielsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
March (Month) 3 (Day) 1912 (Year)

7. AGE
2 yrs. 3 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER E H Nielsen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Edna Stevens

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R M Nielsen
(Address) Maynard

15.
Filed June 28 1914. D O Higgs M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw h[illegible] alive on — 191...,
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:
Accidentally Drowned

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D O Higgs M. D.
June 28 1914 (Address) Soldier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Maynard — DATE OF BURIAL: 6-29-1914

20. UNDERTAKER: Sig Monnett — ADDRESS: Fairfield

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2138
File No. 7050
Registered No. 5

1. PLACE OF DEATH.
County of Blaine
City of Hill City
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Franklin Hazzard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 27 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 409 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blaine Co.

10. NAME OF FATHER: Frank Hazzard

11. BIRTHPLACE OF FATHER (State or Country): Ms

12. MAIDEN NAME OF MOTHER: Lillie Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank J Hazzard
(Address) Hill City Ida.

15.
Filed June 2 1914 O. Riggs M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1914, to June 1 1914, that I last saw him alive on June 1 1914, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. O. Bloom M. D.
June 5 1914 (Address) Hill City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hill City — DATE OF BURIAL: June 6 1914

20. UNDERTAKER: Harris — ADDRESS: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 1795
Registered No. 1

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melissa V. Sharp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or the widow)
6. DATE OF BIRTH: Jan. (Month) 27 (Day) 1 (Year)
7. AGE: 58 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Silas Shurey Ohio
10. NAME OF FATHER: Silas Shurey
11. BIRTHPLACE OF FATHER (State or Country): Pa.
12. MAIDEN NAME OF MOTHER: Mariah Reed
13. BIRTHPLACE OF MOTHER (State or Country): Pa.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christian L. Sharp
(Address) Kimberly Ida
15. Filed June 28 1914 Dr. J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 28 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar. 15 1914, to May 14 1914, that I last saw h er alive on May 14 1914 and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis and Valvular disease Pneumonia
Duration-Several yrs. mos. ds.
Contributory Chronic Nephritis
(Secondary) not known
(Duration) yrs. mos. ds.
(Signed) J. M. Davis M. D.
6/28 1914 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 191
20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7953
Registered No. 8

1. PLACE OF DEATH.
County of Canyon
City of Payette Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Joel P. Love

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: May 2 (Month) (Day) 1852 (Year)
7. AGE: 62 yrs. 1 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): North Carolina
10. NAME OF FATHER: Nathan Love
11. BIRTHPLACE OF FATHER (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Lucinda Lowder
13. BIRTHPLACE OF MOTHER (State or Country): North Carolina
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Manley
(Address) Payette Idaho
15.
Filed June 16 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from [illegible] 191[illegible], to [illegible] 1914, that I last saw h[illegible] alive on [illegible] 1914, and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows:
[illegible]
(Duration) 1 yrs. 0 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) [illegible] M. D.
[illegible] 19[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: June 19 1914
20. UNDERTAKER: Glenn C Landon
ADDRESS: Payette Ida

WYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 7954
Registered No. 9
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Talbot Duncan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1901 (Year)

7. AGE: 13 yrs. 4 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Samuel Duncan

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Lulu May Branham

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nancy Branham
(Address) Payette Ida

15. Filed June 23 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1914, to June 22 1914, that I last saw h[illegible] alive on June 22 1914 and that death occurred on the date stated above, at 4:55 P. M.

The CAUSE OF DEATH* was as follows:
Non-depressed fracture of left temporal left side of occipital and left temporal bones, general sub-arachnoid hemorrhage + punctate hemorrhage throughout brain
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) — yrs. ..... mos. 2 hours ds.

(Signed) J. C. Woodward M. D.
June 23 1914 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: June 24 1914

20. UNDERTAKER: D. N. Adair — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 795
Registered No. 10

1. PLACE OF DEATH. Registration District No.
County of Canyon Primary Registration District No.
City of Payette (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: about 5 months yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs.or* ..... *min.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. A. Robinson
(Address) Nampa Ida

15.
Filed June 27 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Unknown (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191
that I last saw h alive on 191,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Body found in Payette river near Payette
Cause of death Unknown
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) F. A. Robinson Coroner ~~M. D.~~
6/27 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos ds. In the State yrs mos ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette
DATE OF BURIAL: 6/27 1914

20. UNDERTAKER: J. A. Lower & Bro
ADDRESS: Payette Ida

AYMS-VOR CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7956

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Kenaston (No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Schmyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan. (Month) 24 (Day) 1852 (Year)

7. AGE: 62 yrs. 7 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: not known.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs M. H. Demoyer
(Address) Twin Falls Idaho

15. Filed May 1 1914 E. D. Pike Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1913 to April 3 1914, that I last saw h[illegible] alive on April 3 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute indigestion and Chronic Stomach trouble

(Duration) 1 yrs. 3 mos. 21 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Schmerhall M. D.
April 11 1914 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Ida — DATE OF BURIAL: April 13 1914

20. UNDERTAKER: W. J. Freeman — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 107-2017
(No. ....., ... St.)

File No. 7957
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Mable A Saunders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	white	Married

6. DATE OF BIRTH: Aug (Month) 18 (Day) 1893 (Year)

7. AGE: 20 yrs. 10 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Crawford Co Mo

10. NAME OF FATHER: C C Faris

11. BIRTHPLACE OF FATHER (State or Country): Crawford Co Mo

12. MAIDEN NAME OF MOTHER: L E Martin

13. BIRTHPLACE OF MOTHER (State or Country): Crawford Co Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C C Faris
(Address) Jerome Ida

15.
Filed June 27 1914 E. D. Pike
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1914, to June 25 1914, that I last saw h[illegible] alive on June 25 1914 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Rupture of abdominal aneurism

(Duration) 1 yrs. ..... mos. ..... ds.
Contributory (Secondary) Rupture of abd. aneurism
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) E. D. Pike M. D.
7/25 1914 (Address) Jerome Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: June 27 1914

20. UNDERTAKER: D. H. Patterson — ADDRESS: Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gooding
City of
(No. , St.)

Registration District No. 23
Primary Registration District No. 1017-2017

File No. 795
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Margaret Leinbaugh

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Jan 28th - 1913 (Month) (Day) (Year)

7. AGE: 1 yrs. 4 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lewis A. Leinbaugh

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Amelia Hansen Leinbaugh

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis A Leinbaugh
(Address) 10 Mi. S. W. of Jerome

15. Gooding Co.
Filed June 14 1914 C. D. Pipe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191....,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning in Irrigation ditch

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Pipe M. D.
June 14 1914 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary
DATE OF BURIAL: June 15 1914

20. UNDERTAKER: D. A. Harrison
ADDRESS: Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7959

Registration District No. 126

Primary Registration District No. 2204

Registered No. 16

1. PLACE OF DEATH.

County of Kootenai

City of Harrison (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Joseph Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Sept (Month) 16 (Day) 1913 (Year)

7. AGE ..... Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. M. Brown

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER Josephine Heilig

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. C. Brown

(Address) Harrison Ida

15. Filed July 6 1914 R. S. Jensen Local Registrar

SYMS-YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1914, to June 24 1914, that I last saw him alive on June 24 1914, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Acute nephritis

.....(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. K. Pegar M. D.

June 24 1914 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harrison Ida	June 26 1914

20. UNDERTAKER	ADDRESS
E. W. Wheeler	Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7960
Registered No. 15

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Lee Belton.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 9 (Day) 1914 (Year)

7. AGE: ....yrs. 5 mos. 3 ds.
IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Harrison Idaho.

10. NAME OF FATHER: Joe Belton.

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Ester Rice.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Belton
(Address) Harrison Idaho

15. Filed July 6 1914 — R. S. Jensen, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 11 1914, that I last saw him alive on June 11 1914 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Acute Ileo Colitis

(Duration) ....yrs. ....mos. 2 ds.

Contributory (Secondary): .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. M. Kenney M. D.
June 12 1914 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida — DATE OF BURIAL: June 12 1914

20. UNDERTAKER: Evans Mortuary — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STAMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7961
Registered No. 17

1. PLACE OF DEATH.
County of Kootenai
City of Treadmount

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs. Juliana Doty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1825 (Year)

7. AGE: 89 yrs. 6 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Franklin N.Y.

10. NAME OF FATHER: Abner Root

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): - -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Doty
(Address) Coeur d'Alene

15. Filed July 6 1914 R. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1914., to June 24 1914
that I last saw her alive on May 14 1914
and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Fleming M. D.
June 25 1914 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Medimont - Id
DATE OF BURIAL: 6-24 1914

20. UNDERTAKER: E. W. Keeler
ADDRESS: Harrison

See instructions on back of certificate.
ment of OCCUPATION is very important.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 7962
Registered No. 30

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Flora Anderson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 1 (Day) 1910 (Year)

7. AGE: 4 yrs. 3 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C. C. Anderson

11. BIRTHPLACE OF FATHER (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christopher Liljenquist
(Address) Firth Idaho

15. Filed June 2 1914 M. E. Parkin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1914, to June 2 1914, that I last saw her alive on June 2 1914, and that death occurred on the date stated above at 7 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) 4 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Mitchell M. D.
6/2 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Firth Idaho
DATE OF BURIAL: June 2 1914

20. UNDERTAKER: D. H. Bierman
ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 7963
Registered No. 31

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. 12 South Trickes St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kristina Maria Pulsizer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 21 (Day) 1850 (Year)

7. AGE: 64 Yrs. 3 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home mfr
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Gustaf Henrik Invdg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Haney
(Address) Blackfoot, Idaho

15. Filed June 11 1914 — M. Patrick, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-24 1914, to 6-10 1914, that I last saw her alive on 1-9- 1914, and that death occured on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

General Toxemia

(Duration) — Yrs. 2 mos. 15 ds.

Contributory (Secondary) Chronic Nephritis Complicating Pregnancy

(Duration) — yrs. — mos. — ds.

(Signed) C. A. Gibson M. D.
6-11 1914 (Address) Blackfoot Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona City Cem — DATE OF BURIAL: June 11 1914

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

BYNUM - TYPE CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 7064
Registered No. 32

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena London

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mch (Month) 12 (Day) 1901 (Year)

7. AGE: 13 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. F. London

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Maria Young

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur London
(Address) Blackfoot Idaho R F D No 3

15. Filed June 11 1914 — M. E. Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6" 1914, to June 9" 1914, that I last saw h[illegible] alive on June 8" 1914, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Nuritial Pneumonia
and dilatation of heart

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs ..... mos. ..... ds.

(Signed) F. E. Shelley M. D.
6/11 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rye Cem. Fort Hall — DATE OF BURIAL: June 12 1914

20. UNDERTAKER: Lewis F. Davidson — ADDRESS: Blackfoot Route 3

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham — Registration District No. 121

City of Blackfoot R.F.D.#1 — Primary Registration District No. 2194 — (No. ....., ... St.)

File No. 7965

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Wilkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) 27 (Day) 1834 (Year)

7. AGE: 79 Yrs. 9 Mos. 16 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Mainly house building

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Wilkinson

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Mercer

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Calbert Wilkinson

(Address) Blackfoot R.F.D.#1

15. Filed June 13 1914 M. E. Pabie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to June 11 1914, that I last saw him alive on June 1 1914, and that death occured on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Fibroid induration

(Duration) apparently about 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Burn 1st degree of Rt arm.

(Duration — yrs. — mos. 13 ds.

(Signed) W. W. Beck M. D.

6/12 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days — In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hoytsville Utah — DATE OF BURIAL ..... 191...

20. UNDERTAKER: E. I. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

File No. 7966

Registered No. 34

County of Bingham

City of Blackfoot

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irwin.R.Boothe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 20 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER R.E.Boothe

11. BIRTHPLACE OF FATHER (State or Country) Dont know

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E.F.Ruck ~~E.F.Beck~~ coroner

(Address) .....

15. Filed June 22 1914 W.E. Lahrie Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Head crushed by being run over by rail road train

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Ruck Coroner M. D.

19.... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL American Fork Utah

DATE OF BURIAL ..... 191...

20. UNDERTAKER E. F. Ruck

ADDRESS Blackfoot Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7967

Registered No. 33

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot Route 1 (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Estella Rounday

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 5 (Day) 1914 (Year)

7. AGE ... Yrs. ... Mos. 17 ds.

IF LESS than 1 day how many ... hrs. ... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Samuel Edmund Rounday

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Cassie Fullmer

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Edmund Rounday

(Address) Blackfoot, Idaho.

15. Filed June 22 1914 — M. E. Patrick, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1914, to June 22 1914, that I last saw her alive on June 20 1914, and that death occured on the date stated above, at 5:30 AM.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) A. W. Beck M. D.

6/22 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groveland — DATE OF BURIAL: 6/23 1914

20. UNDERTAKER: Samuel E Rounday — ADDRESS

SYMS - YORK CO., PTRS. & BORS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 2164

City of Blackfoot (No. Idaho Insane Asylum St.)

File No. 796

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Conrad

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Don't Know

6. DATE OF BIRTH — — 1836
(Month) (Day) (Year)

7. AGE 78 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Don't Know
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Boyd
(Address) Blackfoot

15. Filed July 2" 1914 M. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 28th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1914, to June 28 1914, that I last saw h— alive on June 28 1914 and that death occurred on the date stated above, at 8-8 P. M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) Don't Know yrs. mos. ds.

Contributory (Secondary) Don't Know

(Duration) Don't Know yrs. mos. ds.

(Signed) Geo. Boyd M. D.

July 19 14 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 17 days. In the State 52 yrs. — mos. — days.

Where was disease contracted if not at place of death? Don't Know

Former or usual residence Blaine County Poor Farm

19. PLACE OF BURIAL OR REMOVAL Insane Asylum Cemetery | DATE OF BURIAL June 30 1914

20. UNDERTAKER Geo. E. Hyde | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Insane Asylum St.)

File No. 7960
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. D. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH
— (Month) — (Day) 1853 (Year)

7. AGE
61 yrs. — mos. — ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo E Hyde
(Address) Blackfoot Idaho

15. Filed July 2" 1914 W. E. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1913, to June 29 1914, that I last saw h in alive on June 29 1914, and that death occurred on the date stated above, at 3-00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) — yrs. — mos. — ds.

Contributory (Secondary): Arterial Sclerosis

(Duration) Dont Know yrs. mos. ds.

(Signed) Geo E Hyde M. D.
July 1 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 11 mos. 6 days. In the State Dont Know yrs. mos. days.
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Ashton, Idaho

19. PLACE OF BURIAL OR REMOVAL: Insane Asylum Cemetery | DATE OF BURIAL: June 30 1914

20. UNDERTAKER: Geo E Hyde | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 701
Registered No. 7

1. PLACE OF DEATH.
County of Owyhee
City of Brunzell

Registration District No. 43
Primary Registration District No. 2120
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: About the year 1886 (Month) (Day) (Year)

7. AGE: 28 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch hand (farmer)
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Paul Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. N. Brunzell
(Address) Brunzell

15.
Filed June 6 1914 — W. H. Salsbury M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...
and that death occurred on the date stated above, at 6.30 A.M.
The CAUSE OF DEATH* was as follows: (Death instantaneous)
Gun-shot wound head, ball entered just above right ear & passed straight through head, coming out just above left ear (thru temporal bones), self-inflicted with suicidal intent
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Salsbury M. D.
June 4 1914 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Brunzell
DATE OF BURIAL: June 7 1914

20. UNDERTAKER: Shellabarger
ADDRESS: Nampa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee.
City of Silver

Registration District No. 43
Primary Registration District No. 2120
(No. ....., ... St.)

File No. 7071
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ida Nelson.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	White	Married.

6. DATE OF BIRTH September 4th 1879
(Month) (Day) (Year)

7. AGE 35 yrs. 10 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work..... House work.
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden.

10. NAME OF FATHER Andrew Pierson

11. BIRTHPLACE OF FATHER (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Bengdetta.

13. BIRTHPLACE OF MOTHER (State or Country) Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Nelson
(Address) Silver City Idaho.

15.
Filed June 12, 1914 N. H. Schuyler M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June, 6, 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Aortic stenosis.

(Duration) three yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. H. Schuyler M. D.
June 12, 1914 (Address) Silver City, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds.
In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Kay P. Cemetary — DATE OF BURIAL: June 9th 1914

20. UNDERTAKER: John Grete. — ADDRESS: Silver City Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 797?
Registered No. 9

1. PLACE OF DEATH.
County of Owyhee
City of Delco

Registration District No. 43
Primary Registration District No. 2120
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Arthur Famine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) 12 (Day) 1832 (Year)

7. AGE: 82 yrs. 7 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book Keeper
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Famine

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Mrs. A. Nellis Silver City, Idaho.

15.
Filed June 13, 1914 W. H. Schuyler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Apoplexy, cerebral.

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Schuyler M. D.
June 13, 1914 (Address) Silver City, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: K of P. Cemetary
DATE OF BURIAL: June 13th 1914

20. UNDERTAKER: John Greta
ADDRESS: Silver City Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No[illegible] M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004

(No. 1665 Hatta St.)

File No. 797

Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara A. Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 30 (Day) 1866 (Year)

7. AGE: 48 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Thomas Smith

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Angeline Custer

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J M Davies

(Address) Boise

15.

Filed 5-2 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1914, to April 30 1914, that I last saw her alive on April 30 1914 and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Phthisis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W H Lukey M. D.

19.... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 2 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 7074

County of Ada

City of Boise (No. 731 E. State St.)

Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Sanders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 1 (Day) 1857 (Year)

7. AGE: 57 Yrs. ——— Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: J. W. Grinnells

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Matilda Root

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D K Sanders

(Address) Boise

15.

Filed 5-4 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1913, to May 2 1914, that I last saw h-r alive on April 30 1914, and that death occured on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis with Mitral Stenosis

(Duration) 1 Yrs. ——— mos. ——— ds.

Contributory (Secondary) Partial Obstruction of Bowels from Carcinoma

(Duration) ——— yrs. ——— mos. ——— ds.

(Signed) W S Parker M. D.

5-2 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 4 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 795

Registered No. 99

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 711½ Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jim Chin Took

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Yellow	Single

6. DATE OF BIRTH. Not attainable (Month) (Day) 1 (Year)

7. AGE about 75 Years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Cook

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) 王 J Wong Lowe

(Address) Boise

15. Filed 5-4 1914 W. J. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to same day 1914, that I last saw him alive on May 1 1914, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

man was dying when I was called

5 (Duration) ~~Yrs.~~ mos. ds.

Contributory (Secondary) Tuberculosis

4 (Duration) yrs. mos. ds.

(Signed) A L Heath M. D.

19 (Address) 505 Overland Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 35 yrs. mos. days In the State 35 yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Chinese Plot — DATE OF BURIAL May 5 1914

20. UNDERTAKER Schreiber & Sidenfaden — ADDRESS Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7976

Registered No. 101

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 Ste St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. H. Brundage

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Oct. (Month) 10 (Day) 1838 (Year)

7. AGE: 75 Yrs. 6 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Gunsmith

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): American

10. NAME OF FATHER: E. W. Brundage

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Brundage

(Address) Echo, Ore.

15.

Filed 5 – 4 1914

M. S. Parker
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1914, to May 13 1914, that I last saw h— alive on May 13 1914 and that death occured on the date stated above, at 11.30

The CAUSE OF DEATH* was as follows:

Spotted fever

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Stuart M. D.

19.... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State 2 yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Oregon

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 5 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada.

City of Boise

Registration District No. 2

Primary Registration District No. 6004

(No. St Luke Hospital St.)

File No. 7044

Registered No. 102

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy M. Disney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Aug (Month) 30 (Day) 1905 (Year)

7. AGE: 8 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Shoshone Ida.

10. NAME OF FATHER: Frank T. Disney

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Louise Berner.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank T. Disney

(Address) Shoshone Ida.

15.

Filed 5-5 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1914, to May 8 1914, that I last saw h[illegible] alive on May 3 1914 and that death occured on the date stated above, at 6:20 M.

The CAUSE OF DEATH* was as follows:

Abscess Endocardium

(Duration) Yrs. 7 mos. ds.

Contributory (Secondary)

Duration Yrs. mos. ds.

(Signed) James L Merritt M. D.

5/4 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 5 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 103 707

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Elizabeth Aurada

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 5th (Day) 1913 (Year)

7. AGE: ..... Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minn Red Cloud Co

10. NAME OF FATHER: Chas P. Aurada

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Mary A Zupfer

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas P Aurada

(Address) Boise Idaho

15. Filed May 6th, 1914

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5th 1914, to May 5th 1914, that I last saw he alive on May 5th 1914, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Concussion of brain

.....(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary): Accident

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. McDonald M. D.

19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. 1 day. In the State .....yrs. .....mos. .....days

Where was disease contracted if not at place of death? .....

Former or usual residence 5 Miles North of Boise

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 5/6 1914

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7011

Registered No. 104

1. PLACE OF DEATH.

County of Ada.

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A. Redway.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow

6. DATE OF BIRTH: Aug 7 1830 (Month) (Day) (Year)

7. AGE: 83 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: Andrew Outterson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Eliza Carroll.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. A. Redway

(Address) Chicago Ill.

15.

Filed ..... 191.....

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1914, to May 9 1914, that I last saw h a l alive on Monday May 4 1914, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Senile degeneration

She was not ill.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.

19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: May 11 1914

20. UNDERTAKER: Fry & Sumner. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7080

Registered No. 106

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 513 North 6th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Balderston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 30 (Day) 1856 (Year)

7. AGE: 57 Yrs. 8 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Register of U S

(b) General nature of industry, business, or establishment in which employed (or employer)... Land Office Boise

9. BIRTHPLACE (State or Country) Cecil County, Maryland

10. NAME OF FATHER Lloyd Balderston

11. BIRTHPLACE OF FATHER (State or Country) U.S.A.

12. MAIDEN NAME OF MOTHER Catherine Canby

13. BIRTHPLACE OF MOTHER (State or Country) U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Balderston Jr

(Address) 513 N 6th St Boise Ida

15. Filed 5-9 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1914, to May 5 1914, that I last saw him alive on May 5 1914, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. 2 mos. 11 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. F. Judge M. D.

May 9 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 11 1914

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7081

Registered No. 108

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St. Luke's Hosp St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Young Clayton Abernathy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 5 (Day) 1874 (Year)

7. AGE: 40 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Stockman

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER John Abernathy

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Permelia Neal

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W W Abernathy

(Address) 1001 N 16 St Boise Idaho

15.

Filed 5-11 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1914, to May 10 1914, that I last saw h in alive on May 10 1914, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Genito Urinary tuberculosis involving kidney, bladder, prostate and testes

(Duration) 7 Yrs. — mos. — ds.

Contributory (Secondary) Secondary glomerulous nephritis

(Duration — yrs. mos. ds.

(Signed) Maurice Henry Dallman M. D.

5/11 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: May 12 1914

20. UNDERTAKER: Troop Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24653

FORM 7 [illegible]

STATE OF IDAHO — CERTIFICATE OF DEATH — State of Idaho, BOARD OF [illegible], Bureau of Vital [illegible]

County of Elmore — Registration District No. 2

City of Mtn Latitude (No. 506 South 5th St.) — Primary Registration District No. 102 — File No. 1304

Registered No. 107

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Wilson Gray.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. March. (Month) 20th (Day) 1885 (Year)

7. AGE: 49 Yrs. 1 Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Stock Man.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Gen. Live Stock

9. BIRTHPLACE (State or Country) Benton Co. Mo.

10. NAME OF FATHER: Daniel Lafayett Gray.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Susan Watson [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. L. Gray.
(Address) Atlanta Idaho.

15. Filed 5-12 1914 — M S Parker, Local Registrar

OVER

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ saw ~~191~~ ~~to~~ 191..., ~~that I last saw him~~ alive on May 8th 1914 and that death occured ~~on the date stated above~~, at ..... M.

The CAUSE OF DEATH* was as follows: Angina Pectoris. Was found dead on account Returned Rocky Bar and Atlanta May 8th 1914 (Duration) by Mail Carrier Yrs ~~mos~~ ~~ds~~.

Contributory (Secondary) Rheumatism

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Adolph Schneider Coroner M. D.

19..... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/13 1914

20. UNDERTAKER: Schneider & Heidenfeld — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 7983
Registered No. 110

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. East 5th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Deborah Wilman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb 22 (Month) 1835 (Day) (Year)

7. AGE: 79 Yrs. 2 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Mr Stronach

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Abagail Aberson

13. BIRTHPLACE OF MOTHER (State or Country): Oswego New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Cora Kinney
(Address) Boise

15. Filed 5-13 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead ~~Jan 10~~ to May 9th 1914, that I last saw h ~~alive on~~ 191, and that death occured on the date stated above, at about 6 A. M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris - No Physician in attendance, Was found dead in bed by her daughter
(Duration) ~~Yrs. mos. ds.~~
Contributory (Secondary): Old Age
(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber M. D.
19 (Address) Boise Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Unknown

19. PLACE OF BURIAL OR REMOVAL: Wales Wisconsin — DATE OF BURIAL: May 14 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24654

FORM [illegible]. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7984

Registered No. 111

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 917 Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alma Mussell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 22 (Day) 1898 (Year)

7. AGE: 16 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Student in

(b) General nature of industry, business, or establishment in which employed (or employer)..... High School

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Jacob Mussell

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Ada Norton

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Mussell

(Address) Caldwell Idaho

15. Filed 5-13 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 2 1914, to May 12 1914, that I last saw h[illegible] alive on May 12 1914, and that death occured on the date stated above, at 7.20 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Typhoid Fever

(Duration) Yrs. mos. ds.

(Signed) M S Parker M. D.

May 13 1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: May 14 1914

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 114

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1310 N. 16th St.)
Registered No. 112

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella J. Jones

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 19 (Day) 1844 (Year)

7. AGE: 69 Yrs. 6 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Simion Jarnett

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Deborah Miles

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Florence A. Bash
(Address) 1310 N-16 St Boise, Idaho

15. Filed 5-14 1914 — M. S. Parker, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1914, to May 13 1914, that I last saw h[illegible] alive on May 13 1914 and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) M. H. Tallman M. D.
5/14 1914 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 15 1914

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 110 East Bannock St.)

File No. 7086

Registered No. 114

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nathan Daniel Chipman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Not obtainable (Month) (Day) 1 (Year)

7. AGE. About 79 Years ... Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Boston Mass.

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (State or Country) U S A

12. MAIDEN NAME OF MOTHER U S A

13. BIRTHPLACE OF MOTHER (State or Country) U S A

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adolph Schreiber

(Address) Boise

15. Filed 5-15 1914 W S Parker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1914, to May 14 1914, that I last saw h— alive on 14 May 1914 and that death occured on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(Duration) ... Yrs. ... mos. 2 ds.

Contributory (Secondary)

(Duration ... Yrs. ... mos. ... ds.

(Signed) R E Shuck M. D.

19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence Ada Co.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery, Ada County Idaho

DATE OF BURIAL: May 15 1914

20. UNDERTAKER: Schreiber & Heidenfelder

ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7987

Registered No. 116

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 904 Reas St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clayton Warner Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 3 (Day) 1898 (Year)

7. AGE: 16 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: High School

(b) General nature of industry, business, or establishment in which employed (or employer): Student

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: A P. Edwards

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sarah A Bartlett

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O P Edwards

(Address) Boise Idaho

15. Filed 5-16 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1914, to May 15 1914, that I last saw him alive on May 14 1914, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis.

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) M. N. Gallagher M. D.

5/16 1914 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: May 17 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 7989
Registered No. 122

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 110 Front Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) 7 (Day) Nov. (Year) 1843

7. AGE: 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Freighter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary A Burns
(Address) Boise

15. Filed 5-21 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) May (Day) 21 1914

17. I HEREBY CERTIFY, That I attended deceased from April 1 1914, to May 21 1914, that I last saw h— alive on 20 May 1914, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage
Arteriosclerosis
(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R E Lemly M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death St Lukes ..... yrs. 2 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 23 1914

20. UNDERTAKER: Schmitz & Siddenfaden — ADDRESS: Boise
Schmitz

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 100
Registered No. 123

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Allen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. (Month) (Day) (Year): 1
7. AGE: 28 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Convict
(b) General nature of industry, business, or establishment in which employed (or employer): Farm Hand
9. BIRTHPLACE (State or Country): Dodge City Kansas
10. NAME OF FATHER: Don't know
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John W. Snook
(Address) Boise Idaho
15. Filed 5-25 1914
M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1914, to May 24 1914, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Geo Callista M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 26 1914
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 7991
Registered No. 125

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 110 East Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Gentry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. (Month) Not ascertained (Day) 1 (Year)
7. AGE: About 21 yrs. Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Nebraska
10. NAME OF FATHER: Not ascertained
11. BIRTHPLACE OF FATHER (State or Country): "
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (State or Country): "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ind Bracken
(Address) 301 N. 16 Boise Idaho
15. Filed 5-26 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 26 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 13 1914, to May 24 1914, that I last saw h- alive on 24 May 1914, and that death occured on the date stated above, at 8 9 M.
The CAUSE OF DEATH* was as follows:
Cardiac Dilitation
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) R E Stuart M. D.
19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/26 1914
20. UNDERTAKER: Schmitt & Hodgin[illegible] — ADDRESS: Boise

BYRD - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7992

Registered No. 128

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 110 East Bannock St.)

2. FULL NAME Wm J. Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not known

(Month) (Day) (Year)

7. AGE about 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. C. Reynolds

(Address) Boise

15. Filed 5-27 1914

M. O. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 23 1914

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June April 1914, to May 21 1914, that I last saw h[illegible] alive on 21 May 1914 and that death occured on the date stated above, at 7 7 M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Alcoholism

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R E Hertz M. D.

19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/28 1914

20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 7093
Registered No. 129

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 509 West So Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Brouillette

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1879 (Year)

7. AGE: 34 Yrs. 9 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Warkerton Ontario. Canada

10. NAME OF FATHER: Theo Schnitzler

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary Strader

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J P Brouillette
(Address) Boise

15.
Filed 5-28 1914 M S Parker
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1914, to ..... 191..
that I last saw her alive on May 8 1914
and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Cancer Uterus

(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E Cluff M. D.
19.... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence 9 x Boise ave So Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Cemetery — DATE OF BURIAL: 5/29 1914

20. UNDERTAKER: Schreiber & Diedenfader — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 7904
Registered No. 130

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 620 Fort St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Callan Ranahan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not obtainable (Month) (Day) 1 (Year)

7. AGE: About 68 Years (Yrs. Mos. Ds.)
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Wm Callan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T Ranahan
(Address) Boise.

15.
Filed 5/29 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1914, to May 27 1914, that I last saw h[illegible] alive on May 27 1914, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Was dead when I arrived
Evidently Heart failure.
(Duration) ....Yrs....mos....ds.

Contributory (Secondary)
(Duration ....yrs....mos....ds.

(Signed) Jos R. Rumpers M. D.
May 27 1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....Shipmond

19. PLACE OF BURIAL OR REMOVAL: Kansas City Mo. DATE OF ~~BURIAL~~: May 31 1914

20. UNDERTAKER: Schreiber & Liedtke ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1054

(No. 1110 Idaho St.)

File No. 7995

Registered No. 131

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Antonio Billeo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 31 (Day) 1848 (Year)

7. AGE: 64 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): a

12. MAIDEN NAME OF MOTHER: a

13. BIRTHPLACE OF MOTHER (State or Country): a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antonio Billeo

(Address) Boise

15. Filed 5/29 1914 S. M. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/25 1914, to 5/29 1914, that I last saw him alive on 5/24 1914, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Puffenbarger M. D.

5/29 1914 (Address) Idaho Bldg Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: 5/31 1914

20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVUS - YORK CO., PTRS. & STNRS. 24854

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 7995

Name Antonio Bilboa

Date of Death May 29, 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death Senility

(Sign here) Fred A. Tetzog M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
(No. ....., ... St.)

File No. 7006
Registered No. 19

1. PLACE OF DEATH.
County of Ada
City of Near Boise
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lee Slagle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan 15 (Month) (Day) 1878 (Year)

7. AGE: 36 Yrs. 3 Mos. 16 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Conrad Slagle

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Sarah Box

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Lucy Slagle
(Address) R F D No 4 Boise

15.
Filed 5-2 1914 MS Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30th 1914, to May 1 1914, that I last saw him alive on May 1 1914, and that death occured on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH* was as follows:
Uremic Poisoning

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Brights disease
(Duration ..... yrs ..... mos. ..... ds.

(Signed) Jos. R. Summers M. D.
May 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 3 1914

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 7997
Registered No. 20

1. PLACE OF DEATH.
County of Ada
City of Near Boise (No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene P. Kingsley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Not Obtainable (Month) (Day) 1845 (Year)

7. AGE: 69 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: E. P. Kingsley

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. G. Burnett
(Address) Soldiers' Home

15. Filed 5-7 1914 — M S Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1910, to 5 5 1914, that I last saw him alive on 5 4 1914, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Bellamy M. D.
5/6 1914 (Address) Idaho Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Urbana Ohio — DATE OF BURIAL: May 11 1914

20. UNDERTAKER: Frey & Sherman — ADDRESS: Boise Id

SVMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

City of Ann Arbor (No. Golden Avenue St.) Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles F Blair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 24 (Day) 1839 (Year)

7. AGE: 75 Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Villa on Civil Way

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: James C F Blair

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Anna Seitz

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margaret Blair
(Address) 1215 N 14 St

15. Filed 5 8 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1914, to May 7 1914, that I last saw him alive on May 6 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Left Side)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred G Tillery M. D.

5/8 1914 (Address) Ann Arbor Mich

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mowris Hill Cemetery — DATE OF BURIAL: May 1914

20. UNDERTAKER: Gray & Sumner — ADDRESS: Ann Arbor

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM No. 10. R. No. 5-25 M. 1-1914.

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. Registration District No. 8

County of Ada Primary Registration District No. 2004

City of Boise (No. ..... St.) Registered No. 1905

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Frederick Dietrich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 5th (Day) 1860 (Year)

7. AGE 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Travelling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Franklin Co Kansas

10. NAME OF FATHER Jacob Dietrich

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Katherine Jackel

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 5 - 11 1914 M. L. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1914, to May 10 1914, that I last saw h[illegible] alive on May 9 1914, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 2 Yrs. 8 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.

1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 5/11 1914

20. UNDERTAKER: Schreiber & Eidemiller | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., STTNR. & ENGR. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

(No. Van Town Addn St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8011

Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of —

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary Magor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Black

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not obtainable (Month) (Day) 1 (Year)

7. AGE: About 60 Years (Yrs. Mos. Ds.)

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not obtainable

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adolph Schreiber
(Address) Boise

15. Filed 5-26 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1914, to May 25 1914, that I last saw h— alive on 25 May 1914 and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R E Shuntz M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: County Plat Morris Hill Cemetery — DATE OF BURIAL: 5/25/1914

20. UNDERTAKER: Schreiber & Redemeyer — ADDRESS: Boise

BYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8001

Registered No. 24

Registration District No. 8

Primary Registration District No. 2004

1. PLACE OF DEATH.

County of Ada

City of near Cole School (No. at Cole School House St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B. Elder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. March (Month) 17 (Day) 1832 (Year)

7. AGE: 82 Yrs. 2 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Josiah L. Elder

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary Gibson

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oren G. Elder

(Address) Boise, Idaho

15.

Filed 5-26 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 22nd 1914, to May 24 1914, that I last saw him alive on May 10th 1914, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cancer of Stomach

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J S Springer M. D.

May 25 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence at Cole School, Ada Co.

19. PLACE OF BURIAL OR REMOVAL: Harris Hill Cemetery — DATE OF BURIAL: 5/26 1914

20. UNDERTAKER: Schreiber & Siddefaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 8002
Registered No. 25

1. PLACE OF DEATH.
County of Ada
~~City of~~ Dean Boise
(No. Diversion Dam ~~St.~~)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Wagner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Widower~~

6. DATE OF BIRTH. Not obtainable (Month) (Day) (Year)

7. AGE: About 60 Years ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not obtainable

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adolph Schreiber
(Address) Boise

15.
Filed 5-26 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased ~~was~~ from dead May 2nd 1914, that ~~I last saw him alive on~~ ~~191~~, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Accidental drowning
at Diversion Dam

(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.

(Signed) Adolph Schreiber M. D.
19.... (Address) Coroner Ada Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence: Shipped

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: May 26 1914

20. UNDERTAKER: Schreiber & Eidenbenz ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8001

Registered No. 26

1. PLACE OF DEATH.

County of Ada

City of [redacted]

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. Idaho State Pen. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ulysses G. Bgarup

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 28 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Convict

(b) General nature of industry, business, or establishment in which employed (or employer) Formerly Sheepherder

9. BIRTHPLACE (State or Country) Cass City Mich.

10. NAME OF FATHER Albert Bgarup

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Smith

(Address) Boise Idaho

15.

Filed 5-27 1914 M. S. Tasker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1914, to May 23 1914, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonary

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jos Edwards M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho State Pen. Cemetery

DATE OF BURIAL: May 27 1914

20. UNDERTAKER: Schreiber & Sidenfaden

ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 800 i
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (infant. unnamed.) Carlson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH: 6 (Month) 18 (Day) 1914 (Year)

7. AGE: — yrs. — mos. — ds.
IF LESS than 1 day how many 11 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Potlatch Ida

10. NAME OF FATHER Gotthard Carlson

11. BIRTHPLACE OF FATHER (State or Country) Sweeden

12. MAIDEN NAME OF MOTHER Matilda Hendrickson

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gotthard Carlson
(Address) Potlatch

15. Filed June 21st 1914 D. J. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-18, 1914, to 6-19 1914 that I last saw him alive on 6-18 1914 and that death occurred on the date stated above, at 10 a/M

The CAUSE OF DEATH* was as follows:
Premature

— (Duration) — yrs. — mos. — ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. LePard M. D.
6-19 1914 (Address) Potlatch Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: June 19 1914

20. UNDERTAKER: Parents. — ADDRESS: Potlatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8005
Registered No.

1. PLACE OF DEATH. Registration District No. 65
County of Latah Primary Registration District No. 2145
City of Potlatch (No. , St.)
If death occurs away from usual residence, give facts called for under special information. Country
2. FULL NAME Robert Harris
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH: June (Month) 13 (Day) 1914 (Year)
7. AGE: ..... yrs. ..... mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: G W Harris
11. BIRTHPLACE OF FATHER (State or Country): Mo
12. MAIDEN NAME OF MOTHER: Lena Kenoyer
13. BIRTHPLACE OF MOTHER (State or Country): Mo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm W E Smith
(Address) Potlatch Idaho
15.
Filed June 15 1914 D. J.W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 13 1914, to June 14 1914
that I last saw her alive on June 13 1914
and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:
Premature -
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo Bock M. D.
..... 19 ..... (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery Garfield. Wash. DATE OF BURIAL: June 16 1914
20. UNDERTAKER: Parents. ADDRESS: Potlatch Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 65.
County of Latah Primary Registration District No. 2145
City of Potlatch (No. ..... St.)
File No. 8044
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roberta - Harris -

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 13 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: G T Harris

11. BIRTHPLACE OF FATHER (State or Country): Ino

12. MAIDEN NAME OF MOTHER: Lena Kenoyer

13. BIRTHPLACE OF MOTHER (State or Country): Ino

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. E. Smith
(Address) Potlatch Idaho

15. Filed June 15th 1914 — Dr. J. W. Thompson, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1914, to June 14 1914
that I last saw her alive on June 13 1914
and that death occurred on the date stated above, at 3:1 M.
The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo T Boyd M. D.
June 15 1914 (Address) Palouse Wn.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery. — DATE OF BURIAL: June 16 1914

20. UNDERTAKER: Parents — ADDRESS: Potlatch Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 50

Primary Registration District No. 2129

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 800

Registered No. 5 15

1. PLACE OF DEATH.

County of Lewis

City of Leo

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Lewis Chance

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) - 16 (Day) 1857 (Year)

7. AGE: 56 Yrs. 5 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... accountant

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Cedar Co Iowa

10. NAME OF FATHER Pleasant William Chance

11. BIRTHPLACE OF FATHER (State or Country) South Carolina

12. MAIDEN NAME OF MOTHER Ruth Finch

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs D. L. Chance

(Address) Leo Idaho

15. Filed 6-15 1914 H C Parrish Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-8 1914, to 6-15 1914, that I last saw him alive on 6-15 1914, and that death occured on the date stated above, at 5:40 a M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Arterial Sclerosis

(Duration not known mos. ds.

(Signed) H. C. Parrish M. D.

6-15 1914 (Address) Leo Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Leo. I.O.O.F. DATE OF BURIAL: 6-16 1914

20. UNDERTAKER: Star Hdw + Furn ADDRESS: Leo Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOLS. 24853

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8008
Registered No. 14

1. PLACE OF DEATH.
County of Lewis
City of Ilo

Registration District No. 50
Primary Registration District No. 2129
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas James Westfall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 1 (Day) 1841 (Year)

7. AGE: 72 yrs. 7 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Land owner
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Augusta, Carrol Co. Ohio

10. NAME OF FATHER: James Westfall

11. BIRTHPLACE OF FATHER (State or Country): New York state

12. MAIDEN NAME OF MOTHER: Elizabeth Snively

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. B. Westfall
(Address) Ilo Ida.

15. Filed June 3 1914 H. C. Parrish Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1914, to June 1 1914 that I last saw him alive on May 31 1914 and that death occurred on the date stated above, at 2 4 M.

The CAUSE OF DEATH* was as follows:
Cardiac failure

..... (Duration) not known yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
..... (Duration) not known yrs. ..... mos. ..... ds.

(Signed) E. L. Burke M. D.
June 3 1914 (Address) Volmer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I C O F Cemetery — DATE OF BURIAL: 6-4- 1914

20. UNDERTAKER: J. J. Wood — ADDRESS: Ilo Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 92
County of Lewis Primary Registration District No. 2170
City of Orofino (No. ....., ... St.)
File No. 5 (2)
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leland E Brammer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 17 (Day) 1894 (Year)

7. AGE: 19 yrs. 8 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E H Brammer

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Lena Stolt

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. H. Brammer
(Address) Orofino Idaho

15. Filed 6-29 1914 E. E. Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Accidentaly Drowned
..... (Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) .....
..... (Duration) ... yrs. ... mos. ... ds.
(Signed) E. E. Watts M. D.
6-29 1914 (Address) Gifford Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grangeville Ida. DATE OF BURIAL: June 3 1914

20. UNDERTAKER: W. E. Stoddard ADDRESS: Gifford Ida

Left of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5r
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 8011
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jeremiah Horton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: September 22nd 1863 (Month) (Day) (Year)

7. AGE: 51 yrs. 9 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Locomotive Hostler
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Henry Horton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Stone

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Horton
(Address) Pingree Idaho

15. Filed 6/13/ 1914 — M. Kenney — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 12 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1914, to June 13 1914 that I last saw h... alive on June 13 1914 and that death occurred on the date stated above, at 7 05 A.M.
The CAUSE OF DEATH* was as follows:
Neurasthenia
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Leo F. Ashley M. D.
June 16 1914 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 27 yrs. ..... mos. 12 ds. Residence Montpelier In the State of Idaho ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: 6/14/ 1914

20. UNDERTAKER: Vincent Bro. — ADDRESS: Montpelier

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. [illegible]

File No. 2801

County of Kootenai

City of Coeur d Alene (No. ....., ... St.)

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Latham Baldwin

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1884 (Year)

7. AGE

30 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wis

10. NAME OF FATHER Wm Boyer

11. BIRTHPLACE OF FATHER (State or Country) Pen

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Pen

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [signature]

(Address) .....

15. Filed May 14 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 11. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1914, to May 11 1914, that I last saw h Er alive on May 11 1914 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Edampsia.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Allwood M. D.

May 219 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Coeur d'Alene	May 15 1914

20. UNDERTAKER	ADDRESS
[signature]	C d A

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 2012
File No. 8013
Registered No. 1

1. PLACE OF DEATH.
County of Madison
City of Victor.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital or institution or camp, give NAME instead of street and number.

2. FULL NAME Baby ~~Smith~~ Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White, American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 9 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 9 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Christopher Lorenzo Butler

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Reba Hutchins

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robt. W. King
(Address) Victor, Idaho.

15. Filed June 9 1914 Robt. W. King Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth, June 9 1914, to death, June 9 1914, that I last saw him alive on June 9 1914, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Congenital Atelectasis

(Duration) Yrs. ..... mos. 9 hours ds.
Contributory (Secondary): Prematurity
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Robt. W. King M. D.
1914 (Address) Victor, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State 9 hours. .....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor, Idaho. DATE OF BURIAL: June 10 1914

20. UNDERTAKER: Stephen Hutchings ADDRESS: Victor Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
(No. .... St.)

File No. 8015
Registered No. 73

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susan Reardon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. 25 (Month) (Day) 1845 (Year)

7. AGE: 68 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: Edmond Riebett

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Pamelia Ray

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. L. Reardon
(Address) Idaho Falls Ida.

15. Filed June 30 1914
Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24852

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 28 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Past 3 yrs. to June 28 1914, that I last saw h[illegible] alive on June 27 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of abdomen

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. L. Fuller M. D.
6/30 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: June 30 1914

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form Y. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 8016
Registered No. 72

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hattie M Tanner

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sep. (Month) 29 (Day) 1876 (Year)

7. AGE: 37 yrs. 8 mos. 25 ds.
IF LESS than 1 day how many ..... hr. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Thomas Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Mary Sherman

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Sullivan
(Address) Idaho Falls, Ida.

15. Filed June 27 1914 C. Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1914, to June 24 1914, that I last saw her alive on June 24 1914 and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Chronic Hypertrophic Splenomegaly

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Leukemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Hammond M. D.
6/27 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 6/28 1914

20. UNDERTAKER: E E Dinwoodey
ADDRESS: Idaho Falls

SVMS. YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8017

Registered No. 171

1. PLACE OF DEATH.

Registration District No. 73

Primary Registration District No. 215-0

County of Bonneville

City of Idaho Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Horace Hunter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 25 (Day) 1874 (Year)

7. AGE: 39 yrs. 6 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock man
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Thomas Hunter

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Cushon

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Hunter
(Address) Idaho Falls

15. Filed June 25 1914 E. E. Lemmon Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1914, to June 21 1914, that I last saw him alive on June 20, 1914 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Aortic Regurgitation

(Duration) Indefinite yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis

(Duration) Indefinite yrs. ..... mos. ..... ds.

(Signed) John O Neil M. D.

6/25 1914 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery Idaho Falls — DATE OF BURIAL: June 25 1914

20. UNDERTAKER: J. H. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 801
Registered No. 70

1. PLACE OF DEATH.
County of Bonneville
City of Poplar
(No. ....., ... St.)

Registration District No. 73
Primary Registration District No. 2140

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME — Wheeler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Dec. (Month) 17 (Day) 1914 (Year)

7. AGE: yrs. 5 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Fred Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Ida Utah

12. MAIDEN NAME OF MOTHER: Miss. Cameron

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred Wheeler.
(Address): Lorenzo R.D.r.

15. Filed June 20 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1914, to May 23 1914 that I last saw her alive on Apr. 21 1914 and that death occurred on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:
Marasmus - Mesenteric Glands.
Gastro-Enteritis

..... (Duration) ..... yrs. 4 mos. - ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray S. Hunter. M. D.
May 24 1914 (Address) Ririe - Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelton Cem.
DATE OF BURIAL: May 25 1914

20. UNDERTAKER: Friends.
ADDRESS: Lorenzo R.D.2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8019

Registered No. 69

1. PLACE OF DEATH. Registration District No. 73

County of Bonneville Primary Registration District No. 2120

City of Idaho Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Cook.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Baby

6. DATE OF BIRTH: Aug 29 (Month) (Day) 1913 (Year)

7. AGE: 1 yrs. 7 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Melvin Cook.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ruth Tyler

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Melvin Cook
(Address) R. D. T. Rigby Ida

15. Filed June 25 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 16 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 11 1914, to Apr. 16 1914, that I last saw her alive on Apr. 15 1914 and that death occurred on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis.
Cerebral toxemia.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray [illegible] M. D.

Apr 17 1914 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ucon — DATE OF BURIAL: Apr 17 1914

20. UNDERTAKER: Friends — ADDRESS: Rigby RD 1 Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO. PRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 8021
Registered No. 42

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonnie Harlow
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1894 (Year)

7. AGE: 16 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Evan Harlow

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Hattie Hoopole

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Evan Harlow
(Address) Idaho Falls Ida.

15.
Filed June 22 1914 C. Thurman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1914, to June 20, 1914, that I last saw her alive on June 20 1914 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Shock following
appendectomy
(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Mellor M. D.
June 22 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: June 22 1914

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2150
(No. Fuller Hospital St.)

File No. 8021
Registered No. 67
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Iona Elvira Wareham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH: June (Month) 20 (Day) 1909 (Year)

7. AGE: 4 yrs. 11 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Iona, Ida

10. NAME OF FATHER: Parley Flitton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ada Madsen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida Wareham
(Address) Idaho Falls RD 1

15. Filed June 16 1914 C. A. Braun Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914 to June 14 1914 that I last saw h alive on June 14 1914 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Appendicitis - Operation
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fuller M. D.
6/16 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls | DATE OF BURIAL: 6/16 1914

20. UNDERTAKER: C. E. Linwood ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 5-6
File No. 8023
Registered No. 61

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth Eugene Waddell
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Aug (Month) 4 (Day) 1908 (Year)

7. AGE: 5 yrs. 10 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: J. E. Waddell

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Ellen C. Nixon

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel E. Waddell
(Address) Idaho Falls Idaho

15. Filed June 11 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1914, to June 4 1914
that I last saw him alive on June 4 1914
and that death occurred on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Septomeningitis

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Jones M. D.
June 6 1914 (Address) Rotonto Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 6 5 1914

20. UNDERTAKER: C. E. Dunwoody
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 802.4
Registered No. 64

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2170

2. FULL NAME Fay Crofts

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: June (Month) 3 (Day) 1914 (Year)

7. AGE: x yrs. x mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: C. W. Crofts

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Maude Jones

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Crofts
(Address) City

15.
Filed June 11 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1914, to June 7 1914, that I last saw her alive on June 5th 1914, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Death followed birth as child was undeveloped

(Duration) ✓ yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
6-7 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 6/8 1914

20. UNDERTAKER: C. E. Dinwoodey
ADDRESS: City

SYMS - YORK CO., PTRS. & BDRS. 19750

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

Primary Registration District No. 2100

File No. 8025

County of Bonneville

City of Iona (No. ....., ... St.)

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maude Ellen Andreasen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January 22 1884 ~~1900~~
(Month) (Day) (Year)

7. AGE: 30 yrs. 4 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Joseph Crofts

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Olive M Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nephi Andreasen
(Address) Iona, Ida

15.
Filed June 10 1914 C. Hammond
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 7 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1914, to June 7, 1914, that I last saw her alive on June 7, 1914, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Nellis M. D.
6/10 1914 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was *disease contracted* if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iona, Ida

DATE OF BURIAL: 6/10 1914

20. UNDERTAKER: C. E. Dunwoody

ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2150
(No. ....., ... St.)

File No. 8027
Registered No. 61
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unknown - Unidentified

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH
? (Month) ✓ (Day) ✓ 1 (Year)

7. AGE
Infant yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓ —
(b) General nature of industry business, or dstablishment in which employed (or employer) ✓

9. BIRTHPLACE (State or Country) ✓ ?

10. NAME OF FATHER ✓ ?

11. BIRTHPLACE OF FATHER (State or Country) ✓ ?

12. MAIDEN NAME OF MOTHER ✓ ?

13. BIRTHPLACE OF MOTHER (State or Country) ✓ ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Hummel
(Address) Idaho Falls Ida

15.
Filed June 6 1917 C. Hummel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 31 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191...,
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Unknown -
Body of Infant found in Snake River Unidentified

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos Morley Coroner M. D.
6/5 1917 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rose Hill Idaho Falls Ida	June 6th 1917
20. UNDERTAKER	**ADDRESS**
Thos. N. Muhleman	Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 35
County of Elmore Primary Registration District No. 2021
City of Glenn's Ferry (No. ....., ... St.)
File No. 8028
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Canfield

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 26th (Day) 1839 (Year)

7. AGE: 74 yrs. 6 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Davis M. D.
(Address) Glenn's Ferry Idaho

15. Filed June 14th 1914 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st 1913, to June 11th 1914
that I last saw her alive on June 10th 1914,
and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Tricuspid Stenosis

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. W. Davis M. D.
June 11 1914 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Glenn's Ferry Idaho — DATE OF BURIAL: June 12th 1914

20. UNDERTAKER: I. P. Shultz — ADDRESS: Glenn's Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia — Registration District No. 39 39

City of Burley — Primary Registration District No. 2087

(No. ....., ... St.)

File No. 8029

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma Ray McDaniel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March 9 (Month) (Day) 1888 (Year)

7. AGE: 26 Yrs. 2 Mos. 7 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Kansas. Atlanta

10. NAME OF FATHER: Charles S. McDaniel

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Mary E. Davies.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles S. McDaniel

(Address) .....

15. Filed May 17 1914

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 9 1914, to May 13 1914, that I last saw him alive on May 13 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Probably 4 yrs.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Wetherbee M. D.

June 1914 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: H B Evans — DATE OF BURIAL: 5/17 1914

20. UNDERTAKER: Burial at Burley — ADDRESS: Burley Idaho

J. H. Murphy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Boise
County of Owyhee
City of Boise
Registration District No. 11
Primary Registration District No. 213
(No. ..., ... St.)
File No. ...
Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Nasby

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
? (Month) 1 (Day) ... (Year)

7. AGE
? yrs. ... mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Information obtained from personal knowledge of deceased
(Address) James P. Kerby, M.D.

15.
Filed 7/19/14 191...
James P. Kerby, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1914, to June 17 1914, that I last saw him alive on June 17 1914, and that death occurred on the date stated above, at 11:00 P. M.

The CAUSE OF DEATH* was as follows:
Fecal Impaction
(Stercoremia)
... (Duration) ... yrs. ... mos. 5 ds.
Contributory (Secondary) Cardiac failure 10 min
... (Duration) ... yrs. ... mos. ... ds.

(Signed) James P. Kerby M. D.
June 18 1914 (Address) Nyswick, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise, Ida	6/20 1914

20. UNDERTAKER	ADDRESS
Owens & Sidebotham	Boise, Idaho

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

FORM V. S. ... REV. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8031
Registered No. .....

Registration District No. .....
Primary Registration District No. 7
(No. ....., ... St.)

1. PLACE OF DEATH.
County of Lincoln
City of Richfield
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adelbert Delevan Crothers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. February (Month) 7 (Day) 1876 (Year)

7. AGE: 36 Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Harness Maker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Allen D Crothers

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Sophronah Campbell

13. BIRTHPLACE OF MOTHER (State or Country): NY

14. THE ABOVE IS TRUE TO THE BEST OF ~~MY~~ KNOWLEDGE.
(Informant) Delbert Crothers
(Address) Richfield Idaho

15.
Filed ..... 191....
J. C. Davies
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1914, to 15 - Inc 1914, that I saw h[illegible] alive on 15 1914, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Spotted (Tick) Fever
(Duration) 12 days Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Davies M. D.
19..... (Address) Richfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: to Shoshone
DATE OF BURIAL ..... 191....

20. UNDERTAKER: O J Barman
ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 40

City of Hollister (No. ..... St.) Primary Registration District No. .....

File No. 8023

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chester S. Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): divorced

6. DATE OF BIRTH. X (Month) X (Day) 1 X (Year)

7. AGE: 53 Yrs. X Mos. X ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: X

11. BIRTHPLACE OF FATHER (State or Country): X

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. I. C. Craig

(Address) Rogerson, Idaho

15. Filed ..... 191 .....

W. R. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 26 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1914, to May 26 1914, that I last saw h(im) alive on May 26 1914 and that death occured on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH was as follows:

Acute Gastro Intestinal
a Grippe Infection

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) W. A. Jarrett M.D.

19 ..... (Address) Hollister, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Twin Falls

DATE OF BURIAL: ..... 191 .....

20. UNDERTAKER: C. J. Crosby

ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & BOOKS. 24858

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Sweet

Registration District No. 6
Primary Registration District No. 2024
(No. ....., ... St.)

File No. 8033
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Jane Cox

PERSONAL AND STATISTICAL PARTICULARS

SEX: ~~Male~~ Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

DATE OF BIRTH: ~~June~~ Jan 16 1844
(Month) (Day) (Year)

AGE: 70 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: ~~Unknown~~ Darwin

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Biggers
(Address) Sweet

15.
Filed ..... 191...
A. G. Byrd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 16 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suspected cause of death — Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) No Physician in attendance M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Braunle — DATE OF BURIAL: June 17 1914

20. UNDERTAKER: F. D. Buchanan — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated in PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DO NOT WRITE IN MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 78036

Registered No. 6

1. PLACE OF DEATH.

County of Latah

City of Bovill

Registration District No. 66

Primary Registration District No. 2146

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Garlacher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 — (Year)

7. AGE: 48 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Lumber Jack.

(b) General nature of industry, business, or establishment in which employed (or employer) Woods.

9. BIRTHPLACE (State or Country) Germany.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patient on entrance to Hospital

(Address) .....

15. Filed 6/19/ 1914

H. Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) — 19 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 - 1914, to June 19 - 1914, that I last saw him alive on June 19 - 1914, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Exposure & Alcoholism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Gibson M. D.

19..... (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 4 days. In the State.....yrs.....mos. 4 days

Where was disease contracted if not at place of death? Lumber Camp.

Former or usual residence Bovill Idaho.

19. PLACE OF BURIAL OR REMOVAL: Bovill — DATE OF BURIAL: 6/22/ 1914

20. UNDERTAKER: J. L. Shampine — ADDRESS: Bovill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Bovill

Registration District No. 66

Primary Registration District No. 2146

(No. ..... St.)

File No. 2036

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Gordon Murphy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 10 (Day) 1891 (Year)

7. AGE: 22 Yrs. ..... Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer): Woods.

9. BIRTHPLACE (State or Country): West Bay City Mich

10. NAME OF FATHER: Patrick Joseph Murphy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Sarah Tobin

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. P. Murphy

(Address) Bovill Idaho

15. Filed 6-8-1914

F. C. Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7 (Day) - 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1914, to June 7 1914, that I last saw him alive on June 7 - 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Alcoholism

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. C. Gibson M. D.

19.... (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill Idaho. DATE OF BURIAL: June 8 1914

20. UNDERTAKER: J. L. Shamplin ADDRESS: Bovill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Potlatch

(No. ....., ... St.)

Registration District No. 66

Primary Registration District No. 2176

File No. 8

Registered No. 7803

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Brosseau

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) — 1 (Year)

7. AGE: 4 Yrs. 6 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: Ed Brosseau

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Frei

(Address) Collins Idaho

15. Filed 3/14/ 1914 F. E. Gibson Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Burning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Burns Burned.

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Gibson M. D.

1914 (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill Idaho — DATE OF BURIAL: 3/14/ 1914

20. UNDERTAKER: J. L. Champion — ADDRESS: Bovill Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Collins

(No. ....., ... St.)

Registration District No. 66

Primary Registration District No. 2146

File No. 9803

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Brosseau

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) — (Year)

7. AGE: 3 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: Ed Brosseau

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Frei

(Address) Collins Idaho

15. Filed 3/14/1917

H C Gibson
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 — 13 — 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191—, that I last saw h... alive on — 191—, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Accident of Burning.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Burns Burned.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H C Gibson M. D.

19.... (Address) Bovill

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill Idaho — DATE OF BURIAL: 3/14/1917

20. UNDERTAKER: J L Champion — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Bovill

(No. ....., ... St.)

Registration District No. 66

Primary Registration District No. 2176

File No. 10804

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Brosseau

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. — (Month) — (Day) 1 — (Year)

7. AGE / Yrs. 6 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER Ed Brosseau

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Frei

(Address) Collins - Idaho

15. Filed 3/14/1914

F. C. Gibson
Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 — (Month) 12 — (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191... to — 191..., that I last saw h— alive on — 191..., and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Burning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) House Burned

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) F. C. Gibson M. D.

19.... (Address) Bovill - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bovill - Idaho — DATE OF BURIAL 3/14/1914

20. UNDERTAKER F. L. Shampine — ADDRESS Bovill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2139
File No. 7
Registered No. 8041

1. PLACE OF DEATH.
County of Blaine
City of Arco
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George Callas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 25 (Day) 1881 (Year)

7. AGE: 32 yrs. 8 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section hand
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: John Callas

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Katherine Corolis

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Callas
(Address) Arco - Idaho

15. Filed 5/28 1914 Ew Toms Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191...
that I last saw h~ alive on ~ 191...,
and that death occurred on the date stated above, at ~ M.

The CAUSE OF DEATH* was as follows:
Shot through mouth + Abdomen
Death probably immediate
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello
DATE OF BURIAL: 5-29 1914

20. UNDERTAKER: E. J. Peck
ADDRESS: Blackfoot

YMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2200
File No. 8043
Registered No. 7

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Interstate Mine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michall Crotty (Croteau)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH.
(Month) (Day) 1 (Year)

7. AGE
56 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: lumberman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Carlyle Canada

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr. Powers
(Address) Wallace Ida

15. Filed 5/14 1914 H. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) ... Yrs. ... mos. 7 ds.
Contributory (Secondary) Chronic Valvular Heart disease
(Duration) 3 yrs. ... mos. ... ds.

(Signed) Dr. Mowery M. D.
May 11 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: May 12 1914
20. UNDERTAKER: Bruce Norelle — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2205
File No. 8044
Registered No. 9

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Main St. Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Augusta Henry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. February (Month) 14 (Day) 1845 (Year)

7. AGE: 29 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: T. H Kuig

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: M. Fithian

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Henry
(Address) Wallace Ida

15. Filed May 23 1914 W. J. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1914 to May 3 1914 that I last saw h[illegible] alive on May 10 1914 and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Cerebral Apoplexy

(Duration) ..... Yrs. Few Hours

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Mowry M. D.
May 23 1914 (Address) Wallace Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Galena Kansas
DATE OF BURIAL: May 24 1914

20. UNDERTAKER: R G Mostell
ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of Parker

Registration District No. 99

Primary Registration District No. 217

(No. ..... St.)

File No. 8047

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vonnetta Secrist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec 26 (Month) (Day) 1897 (Year)

7. AGE: 17 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Student

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Parker Idaho

10. NAME OF FATHER Geo Secrist

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Henrietta Miles

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Stockgard

(Address) Parker Idaho

15. Filed June 9 1914

W D Wyatt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h— alive on ——— 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Coroners Verdict—Was Suicide probably Strychnine poisoning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W D Wyatt M. D.

May 13 1914 (Address) St Anthonys

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker — DATE OF BURIAL: 13 May 1914

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 804

Registered No. 23

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. ....., Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tracy B. Dunwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Widowed

6. DATE OF BIRTH

May (Month) 12 (Day) 1832 (Year)

7. AGE

81 yrs. 11 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada,

10. NAME OF FATHER L. Brannen

11. BIRTHPLACE OF FATHER (State or Country) Ireland,

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dan B Dunwell

(Address) Lewiston Ida

15.

Filed June 10 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1912, to May 7 1914, that I last saw her alive on May 7 1914, and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Senile debility

several (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L J Perkins M. D.

5/7 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho. DATE OF BURIAL: May 8 1914

20. UNDERTAKER: J Vanstan ADDRESS: Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8047
Registered No. 24

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. ..., Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George Rule

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: June — 1860 (Month) (Day) (Year)

7. AGE: 54 yrs. — mos. — ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Geo Rule

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Mary Anne Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant):
(Address) Thomas Rule Butte Mont.

15. Filed June 10 1914 L. O Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 11 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 1 1914, to May 10 1914 that I last saw h in alive on May 9 1914 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis.
Cirrhosis of Liver.
Chronic Nephritis.

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary): Same

(Duration) 2 yrs. — mos. — ds.

(Signed) Edgar L. White M. D.

May 11 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: May 12 1914

20. UNDERTAKER: L. Larson — ADDRESS: Lewiston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 805

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston Ida

Registration District No. 96
Primary Registration District No. 1009
(No. 2112, 8th Ave E. St.)

2. FULL NAME Elizabeth Keacher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: July 25th 1843
(Month) (Day) (Year)

7. AGE: 70 yrs. 9 mos. 25 ds.
IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Franz Laber

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. C. Canaan M.D.
(Address) 570 main St Lewiston Ida

15.
Filed June 10 1914 L. Wickes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 20th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19th 1914, to May 20th 1914
that I last saw her alive on May 19th 1914
and that death occurred on the date stated above, at 12 P.M.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. 14 ds.

(Signed) O. C. Canaan M. D.
May 20th 1914 (Address) 570 main St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: May 22 1914

20. UNDERTAKER: J. Vassar
ADDRESS: Lewiston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8051

Registered No. 26

1. PLACE OF DEATH.
County of Nez Perce Idaho
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Rudolph Hoffman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: October (Month) 23 (Day) 1875 (Year)

7. AGE: 38 yrs. 7 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John Hoffman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Jimm

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Hoffman
(Address) Asotin, Wash

15.
Filed 6-10-1914 L.J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 25 1914, to May 22 1914
that I last saw him alive on May 21 1914
and that death occurred on the date stated above, at 2.15 A.M.
The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... yrs. ..... mos. 30 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E Taylor M. D.

May 22 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 27 ds. In the State ..... yrs. ..... mos. 27 ds.
Where was disease contracted, if not at place of death? Asotin Wash
Former or usual residence Asotin Wash

19. PLACE OF BURIAL OR REMOVAL: Asotin, Wash
DATE OF BURIAL: 5/25 1914

20. UNDERTAKER: H.R. Merchant
ADDRESS: Asotin Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8052

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 95

Primary Registration District No. 1009

County of Nez Perce

City of ~~of~~ Jammany (No. ....., ... St.)

2. FULL NAME Kenneth Bruce Blackwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: May (Month) 13 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Nez Perce Co. Idaho

10. NAME OF FATHER: Geo. A. Blackwell

11. BIRTHPLACE OF FATHER (State or Country): Ontario, Canada

12. MAIDEN NAME OF MOTHER: Sarah Anderson

13. BIRTHPLACE OF MOTHER (State or Country): North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Blackwell
(Address) Lewiston, Idaho

15.
Filed 6-10-1914 L Peckens
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No attending Physician, Dr. Shaff of Lewiston, attended Mother in confinement

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jammany, Idaho

DATE OF BURIAL: May 24, 1914

20. UNDERTAKER: No Undertaker

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8053
Registered No. 10

1. PLACE OF DEATH.
County of Kootenai
City of C. D. A.

Registration District No. 29.
Primary Registration District No. 1050
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant White

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 21 (Day) 1914 (Year)

7. AGE: ....yrs. ....mos. ....ds.
IF LESS than 1 day how many 3 hrs. or ....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ed. H. White

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Nellie E. Humbley

13. BIRTHPLACE OF MOTHER (State or Country): Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed H White
(Address) Coeur D'Alene

15.
Filed April 28 1914 V. V. Forrest
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21" 1914, to Apr 21st 1914 that I last saw h-r alive on Apr 21st 1914 and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Premature birth.

..... (Duration) - yrs. - mos. - ds.

Contributory (Secondary) .....
..... (Duration) - yrs. - mos. - ds.

(Signed) W H Haeden M. D.
Apr 21 1914 (Address) Coeur d Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: Apr 24 1914

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. 2 St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29.
Primary Registration District No. 1050.

File No. 2805.4
Registered No. 9.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clayton Hutchins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 12 (Month) 16 (Day) 1913 (Year)

7. AGE: yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Melvin Hutchins

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Frances Tierney

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Melvin Hutchins
(Address) .....

15. Filed April 15 1914. W. McDonald Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191, to — 191, that I last saw him alive on April 9 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) Failure of closure of foramen ovale

(Duration) — yrs. 3 mos. 28 ds.

(Signed) W. H. Hoaden M. D.

4/14 1914 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Apr 15 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29.

Primary Registration District No. 1050

File No. 2805

Registered No. 6

County of Kootenai

City of Post Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Teddy Lindley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... (Month) ..... (Day) 1906 (Year)

7. AGE

8 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry Lindley

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Mary Grant

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed April 15 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 7 1914

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22 1914, to April 7 1914, that I last saw him alive on April 7 1914 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Myers M. D.

April 7 1914 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Garfield Wash. DATE OF BURIAL: 1914

20. UNDERTAKER: [illegible] ADDRESS: [illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK COR PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29.

Primary Registration District No. 1050

File No. 2 805

Registered No. 5.

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin Warren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

..... 1 —
(Month) (Day) (Year)

7. AGE

About 53 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) —

(Address) —

15.

Filed Apr 10 1914 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 23rd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1914, to April 22nd 1914, that I last saw him alive on April 22 1914, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

..... (Duration) 10 yrs. — mos. — ds.

Contributory (Secondary) Secondary dropsy

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Jas Busby M. D.

April 25 1914 (Address) Coeur D'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	Apr 30 1914

20. UNDERTAKER	ADDRESS
D. J. Lenon	Coeur D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1020

File No. 805
Registered No. ....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Kress

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1868 (Year)

7. AGE
45 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) U. S.

10. NAME OF FATHER Kress

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lee Heymann
(Address) Coeur D'Alene

15.
Filed April 10 1914 M. L. Dolan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 1 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Found dead cause of death unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. L. Dolan M. D.
April 1914 (Address) Cd'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	Apr. 12 1914

U. UNDERTAKER	ADDRESS
Cassedy & Nelson	Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2805

Registered No. 3

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. [illegible]
City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lisa Lundell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Dec. (Month) ..... (Day) 1825 (Year)

7. AGE: 89 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Nelson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Dont-Know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. P. Nelson
(Address) .....

15. Filed April 28 1914 Max C. Boland
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23 1914, to April 27 1914
that I last saw her alive on April 23 1914
and that death occurred on the date stated above, at 5-9 M.
The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis.

..... (Duration) Don't Know yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John D. Wood M. D.
April 28 1914 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Apr 28 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2452
File No. 8059
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Liberty
(No. 40, ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth P. Symms.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	W	Married

6. DATE OF BIRTH Dec 12 1842
(Month) (Day) (Year)

7. AGE 42 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Robert Penn

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Susan Jane Shaw

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. P. Symms
(Address) Grays Lake Ida

15.
Filed 5/29 1914 C. J. Burton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1914, to May 26 1914, that I last saw her alive on May 24 1914, and that death occurred on the date stated above, at ? P. M.

The CAUSE OF DEATH* was as follows: Heart (Myocardial degeneration)

? (Duration) ? yrs. ? mos. ? ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Corley M. D.
May 27 1914 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Liberty	5/28 1914

20. UNDERTAKER	ADDRESS
W R Morgan	Liberty

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Paris

Registration District No. 53
Primary Registration District No. 2132
(No. ....., ... St.)

File No. 8061
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Innes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: October 17 (Month) (Day) 1859 (Year)

7. AGE: 54 yrs. 5 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Thomas Innes

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Coultit

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Innes
(Address) Paris, Ida.

15. Filed 5/31/ 1914 R. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 24 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1914, to April 24 1914
that I last saw him alive on April 24 1914
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Cerebro sclerosis.
..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) A. D. Cox M. D.
May 24 1914 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Idaho
DATE OF BURIAL: 2/26 1914

20. UNDERTAKER: Bishop Sutton
ADDRESS: Paris Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8065
Registered No. 15

1. PLACE OF DEATH.
County of Jefferson
City of Ammon
Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. W. D. Morgan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH Aug (Month) 20 (Day) 1872 (Year)

7. AGE ~~41~~ 41 yrs. 9 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.... Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Edward Kimber.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Mary Pembrooks.

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Morgan
(Address) Ammon Idaho
Forney, Idaho.

15.
Filed ..... 191...
Ray N. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 P.M 1914, to 6-30 P.M 1914
that I last saw her alive on June 8 1914
and that death occurred on the date stated above, at 8 45 P.M.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

..... (Duration) few hrs yrs. mos. ds.

Contributory (Secondary) Trauma

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray N. Fisher M. D.

June 8 1914 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lyman Cemetary	June 10 1914
20. UNDERTAKER	ADDRESS
M. T. Peck & Sons	Rigby Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 98
County of Jefferson Primary Registration District No. 2176
City of Saint. (No. ....., ... St.)
File No. 8064
Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dudley Wilson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Bach.
6. DATE OF BIRTH: June (Month) 7th (Day) 1914 (Year)
7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many .. hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Bruce Wilson
11. BIRTHPLACE OF FATHER (State or Country): Utah.
12. MAIDEN NAME OF MOTHER: Louisa Lee.
13. BIRTHPLACE OF MOTHER (State or Country): England.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bruce Wilson
(Address) Idaho Falls R.F.D. 5
15. Filed June 10 1914 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 8th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 7th 1914, to June 8 1914
that I last saw him alive on June 7 1914
and that death occurred on the date stated above, at 5A. M.
The CAUSE OF DEATH* was as follows: -
Atelectasis -
Congenital Heart
(Duration) Weakness yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ray H. Fisher M. D.
June 8 1914 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grant Cemetery. DATE OF BURIAL: June 8th 1914
20. UNDERTAKER: Friends. ADDRESS: Idaho Falls R.F.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

V. S.—No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. Age should be stated exactly. Physicians should state cause of death in plain terms, that it may be properly classified. The "Special Information" for persons dying away from home should be given in every instance.

PLACE OF DEATH

County of Kootenai

Town of Plummer

or

City of ..... (No. ..... St. ..... Ward.)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

WASHINGTON STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Record No. 8067

File No. 7

Registered No. (38) 26

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Full Name Benjaman F. Coplen

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR: White

DATE OF BIRTH: Dec (Month) 18 (Day) 1842 (Year)

AGE: 71 years, 5 months, 25 days

SINGLE, MARRIED WIDOWED, OR DIVORCED: Widower

BIRTHPLACE (State or country): Fulton Co. Ind.

NAME OF FATHER: Henry Coplen

BIRTHPLACE OF FATHER (State or country):

MAIDEN NAME OF MOTHER: Diana Starnes

BIRTHPLACE OF MOTHER (State or country):

OCCUPATION: Mining Engr.

THE ABOVE STATED PERSONAL PARTICULARS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

(Informant) A B Coplen

(Address) Plummer Ida

Filed 5-20-14 Marie Boland Registrar.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 17 (Day) 1914 (Year)

I HEREBY CERTIFY, That I attended deceased from July 1912 to May 12 1914

that I last saw him alive on April 30 1914

and that death occurred, on the date above, at 7-10 P.M.

The CAUSE OF DEATH was as follows:

General paresis, following Apoplexy

(Duration) Days

Contributory —

(Duration) Days

(Signed) J. A. Nelson, M. D.

5/13 1914 (Address) Tyson Wash

SPECIAL INFORMATION only for Hospitals, Institutions, Transients or Recent Residents.

Former or Usual Residence

How Long at Place of Death?

Where was Disease Contracted?

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Latah, Wash.	May 14 1914

UNDERTAKER: Moore

ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of C d A
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 7 806
Registered No. 35
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles H Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	Single

6. DATE OF BIRTH
..... 1
(Month) (Day) (Year)

7. AGE
45 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Agent
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Wis

10. NAME OF FATHER John E Thomas

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER — Shoudman

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. B. Stecher
(Address) 508 Cedar St

15. Filed May 14 1914 J. M. Rossland
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Shock fr Internal Hem 2 2
Skull fracture

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Kleinhans M. D.
19.... (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Spokane | DATE OF BURIAL: .....191...

20. UNDERTAKER: [illegible] | ADDRESS: C. d. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 2062
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Burkhard H Runk

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	Married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1877 (Year)

7. AGE
37 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Worker
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ind

10. NAME OF FATHER James Runk

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Amanda —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) [illegible]

15. Filed May 31 1914 [signature]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Struck by Island train Frt 22
Skull fracture

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane	191...

20. UNDERTAKER	ADDRESS
[signature]	[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of C d A
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. X1171
Registered No. 23
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank St Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	single

6. DATE OF BIRTH
..... (Month) ..... (Day) 19 00 (Year)

7. AGE
14 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many .....*hrs.* or .....*mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm J. McDonald
(Address) Kingston Ida

15. Filed 6-31 — 1914 McDonald
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 31st 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowned in Hayden Lake.
Was in swimming with three other boys.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] Coroner M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Spokane | DATE OF BURIAL: .....191...

20. UNDERTAKER: [illegible] | ADDRESS: C d A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

File No. 20712

County of Kootenai

City of Coeur d'Alene (No. ..... St.)

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unknown

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: — (Month) (Day) 1 (Year)

7. AGE: about 60 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sherman Bailey

(Address) Coeur d'Alene

15. Filed May 29 1914 M. A. Leland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: about May 15 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mr Brown - probably drowned accidentally

— (Duration) — yrs. — mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Shelton Coroner M. D.

19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Lawn — DATE OF BURIAL: May 30 1914

20. UNDERTAKER: S. J. Lewis — ADDRESS: Coeur d'Alene

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of C. D. A.

Registration District No. 29
Primary Registration District No. 1056
(No. ....., ... St.)

File No. 2111
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Riley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1880 (Year)

7. AGE: 33 yrs. 7 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Isaac Trudeau

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Adeline Bremitt

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Riley
(Address) .....

15. Filed 5/27/1914 Mark Dorland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 26d (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1914, to May 26d 1914 that I last saw her alive on May 24d 1914 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.
had been under treatment (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alexander Baerre M. D.
May 27 1914 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Thomas Cem. DATE OF BURIAL: May 28 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8072
Registered No. 80

1. PLACE OF DEATH.
County of Kootenai
City of Idaho

Registration District No. 29
Primary Registration District No. 1650
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christine Hager,

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widow

6. DATE OF BIRTH: January (Month) 1st (Day) 1834 (Year)

7. AGE: 80 yrs. 4 mos. 25 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland, Belfast

10. NAME OF FATHER: John Johnson

11. BIRTHPLACE OF FATHER (State or Country): Ireland, Belfast

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Busby
(Address) 510 Foster Ave

15. Filed May 25 1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913, to May 1914, that I last saw her alive on May 24 1914 and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Cancer of the breast

(Duration) 80 yrs. 4 mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Busby M. D.
19 (Address) Coeur D'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. — DATE OF BURIAL: May 27 1914

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d Alene

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 8074
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Smedahl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
(Month) (Day) (Year) 1871

7. AGE
43 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Wife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER — July

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. K. Smedahl
(Address) [illegible]

15. Filed May 2 1914 Mary E. Delaney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 1st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1914, to April 26 1914, that I last saw h[illegible] alive on April 26 1914 and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary and intestinal Tuberculosis

about
(Duration) 14 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.

(Signed) W. H. Holden M. D.
5/2 1914 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Lawn	May 3 1914

20. UNDERTAKER	ADDRESS
C. J. Luer	C. W. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8175
Registered No. 18

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. ....., ... St.)

Registration District No. 29
Primary Registration District No. 1950

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas G. Miller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH Aug (Month) 22 (Day) 1866 (Year)

7. AGE 47 yrs. 8 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Clerk
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Chas Miller

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C. G. Miller
(Address) East Falls

15. Filed May 15th 1914 Wm. A. Doran Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 12 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 4 1914, to May 12 1914
that I last saw him alive on May 12 1914
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Pemphigus

(Duration) ..... yrs. 3 mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Mayo M. D.
May 13 1914 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Evergreen Cem — DATE OF BURIAL May 14 1914

20. UNDERTAKER Cassedy & Nelson — ADDRESS Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Cda
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20,
Primary Registration District No. 1650
(No. ....., ... St.)

File No. 2057
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Chant

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widowed

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 54 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Musical
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Henry Chant

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) [illegible]

15. Filed May 4 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 4 (Day) 191X (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st 191X, to May 4 191X, that I last saw him alive on May 3rd 191X, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Diabetes

(Duration) 5 yrs. — mos. — ds.
Contributory (Secondary) Cystitis
(Duration) 2 yrs. — mos. — ds.

(Signed) Jno Bunby M. D.
May 4 1914 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: S J Lunn
ADDRESS: Cda

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29.

Primary Registration District No. 1050

File No. 2417

Registered No. 15.

County of Kootenai

City of ..... (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant son of Robert Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May 11 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Robert Baker

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Katharine Vogler

13. BIRTHPLACE OF MOTHER (State or Country): Can

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Baker

(Address) C D A

15. Filed May 14 1914 M. McFarland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1914, to May 14 1914, that I last saw h im alive on May 14 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Uremia.

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John D Lloyd M. D.

May 14 1914 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: May 15 1914

20. UNDERTAKER: S J Lee — ADDRESS: Cda

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BKRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3807
Registered No. 74

1. PLACE OF DEATH. Registration District No. 20
County of Kootenai Primary Registration District No. 1050
City of Dalton Gardens (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annalane Phillips

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: 7 (Month) 30 (Day) 1841 (Year)

7. AGE: 72 yrs. 9 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ont.

10. NAME OF FATHER: John Emerson

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth McGuire

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo E Wilson
(Address) .....

15. Filed 5-18 1914 W. R. Copland, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1912, to May 18 1914 that I last saw her alive on March 10 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John T. Wood M. D.
May 18 1914 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: May 19 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2 8080
Registered No. 13

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Johnston

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 27 (Day) 1859 (Year)

7. AGE: 54 yrs. 9 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Geo. Johnston

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Ann Moncrieff

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Doyle
(Address) .....

15. Filed 6-18 1914 M. Ward. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1913, to May 17 1914
that I last saw him alive on May 17 1914
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis — Chronic Interstitial Nephritis

(Duration) 2 yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Doyle M. D.
May 17 1914 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: May 18 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29.

Primary Registration District No. 1050

File No. 3481

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie M Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1873 (Year)

7. AGE

41 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Wife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER E O Imbry

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M E Nelson

(Address) 106 9th St Coeur d'Alene Ida

15. Filed May 19 1914 M A Leland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 17 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Nov 16 1913, that I last saw her alive on Nov 16 1913, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Multiple Neuritis

..... (Duration) 1 yrs. 6 mos. — ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J O Voyrs M. D.

May 19 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Lawn	May 19 1914

20. UNDERTAKER	ADDRESS
S J Lewis	C d A

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8082
Registered No. 6

1. PLACE OF DEATH.
County of Blaine
City of Hill City
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2138

2. FULL NAME Elbert Mayfield Jones

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec 10 1857 (Month) (Day) (Year)

7. AGE: 59 yrs. 6 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Buchanan Co Iowa

10. NAME OF FATHER: Alpheus Jones

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Zibbah Evans

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ott L. Jones
(Address): Hill City

15.
Filed June 23 1914 D A Higgy M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:
Died suddenly
Chronic Valvular Heart Disease
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O R Bloom M. D.
6-21-1914 (Address) Hill City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hill City Ida — DATE OF BURIAL: June 23 1914

20. UNDERTAKER: Harris — ADDRESS: Hailey Ida

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Caldwell (No. ....., ... St.)
File No. 8087
Registered No. 38
If death occurs away from usual residence, give facts called for under special information. If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ida M. Killen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: March (Month) - 6 (Day) - 1887 (Year)
7. AGE: 37 yrs. 3 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wis.
10. NAME OF FATHER: W. G. Creasy
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Axtell
13. BIRTHPLACE OF MOTHER (State or Country): Wis.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Killen
(Address) Caldwell
15. Filed June 20 1914 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 19 1914, that I last saw her alive on June 18 1914, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Typhoid fever
(Duration) ..... yrs. ..... mos. 9 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. L. Gue M. D.
6/19 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: June 20 1914
20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

[redacted]E OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration [redacted] 3

County of Canyon Co. Primary Registration District No. 1005

File No. 8084

City of Caldwell (No. ....., ... St.)

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. A. Goldsmith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 11 (Day) 1 (Year)

7. AGE: 43 yrs. 8 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Contractor
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: John Goldsmith

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary Hoglan

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Emma L. Kisl
(Address) Nampa Idaho

15.
Filed 6/16/ 1914 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..... 191..., to ..... 191...
~~that I last saw h..... alive on~~ ..... 191...,
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Automobile Accident

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred K Robinson ~~M. D.~~ Coroner
6/14 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was Disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Nampa
DATE OF ~~BURIAL~~: June 16 1914

20. UNDERTAKER: W. C. Dyer
ADDRESS: Caldwell Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 3
County of Canyon
Primary Registration District No. 2005
City of Caldwell Poor farm (No. ..., ... St.)
File No. 9089
Registered No. 36
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George A. Stewart.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
About (Month) (Day) 1847 (Year)

7. AGE
About 67 yrs. ... mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Not Obtainable.

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A A Farris
(Address) Caldwell Idaho

15.
Filed June 23rd 1914 John L. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1914, to May 8th 1914, that I last saw him alive on May 7 1914, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ... yrs. ... mos. 1 ds.
Contributory (Secondary) None
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. Meyer M. D.
May 8 1914 (Address) J. Meyer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: June 23 1914

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 63

Primary Registration District No. 2142

File No. 8086

County of Latah

City of Genesee (No. ....., ... St.)

Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mersel E. Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May 26 1848 (Month) (Day) (Year)

7. AGE: 66 yrs. 7 mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers wife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Geo Rogers McGlothlen

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Betsy Cain

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jacob S Rogers
(Address): Genesee Idaho

15. Filed June 6th 1914 W. N. Ekern Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 6 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1914, to May 30 1914, that I last saw her alive on May 30 1914, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McCall M. D.

June 6 1914 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch — DATE OF BURIAL: June 8 1914

20. UNDERTAKER: F. E. Lambert — ADDRESS: Genesee

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 63
Primary Registration District No. 2142

File No. 8087
Registered No. 6

1. PLACE OF DEATH.
County of Latah
City of Genesee
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myra Hallister

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 13 (Day) 1855 (Year)

7. AGE: 58 yrs. 11 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Silverton Oregon

10. NAME OF FATHER: B. Camp

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Mulvala

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. V. Brewster
(Address) Genesee

15.
Filed June 20 1914 W. S. Cohen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1914., to June 16 1914
that I last saw her alive on June 16 1914
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) W. N. Cohen M. D.
June 20 1914 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lot 7 — DATE OF BURIAL: June 20 1914

20. UNDERTAKER: J. E. Lambert — ADDRESS: Genesee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STAR-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8087

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls. Registration District No. 39

City of Burley (No. ....., ... St.) Primary Registration District No. 2087

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~

6. DATE OF BIRTH. Oct (Month) 14 (Day) 1837 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: X

(b) General nature of industry, business, or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Burke

10. NAME OF FATHER: E. L. Baker

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Sarah Carman.

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Baker

(Address) Burke

15.

Filed June 28 1914 J. H. Humphrey Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-27 1914 to 6-27 1914, that I last saw h. alive on 6-27 1914, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Kicked by horse.

(Duration) about ½ hour

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Humphrey M. D.

6-28 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buried — DATE OF BURIAL: June 28 1914

20. UNDERTAKER: A B Evans — ADDRESS: Burke

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
(No. ..... St.)

File No. 8089
Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls.
City of (or Town) W. A. S. Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm M. Dingley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Mar

6. DATE OF BIRTH. Aug 15 - 18
(Month) (Day) (Year)

7. AGE 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Wm M. Dingley

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Julia Dingley

13. BIRTHPLACE OF MOTHER (State or Country) Alabama.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Louis Dingley
(Address) .....

15. Filed 6-4 1914
J. M. Merrifield
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-3 1914, to 6-4 1914, that I last saw h[illegible] alive on June 3 1914, and that death occured on the date stated above, at 1:0 P M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis.

(Duration) Not Known mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Merrifield M. D.
6-4 1914 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls.	6-7 1914

20. UNDERTAKER	ADDRESS
C. J. Crosby	Twin Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2010
Primary Registration District No.
(No. , St.)

File No. 2091
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME David D. Malcolm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dont Know (Month) (Day) 1 (Year)

7. AGE: 25 about yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): T. H. Dr[illegible]
(Address): Emmett Idaho

15.
Filed 6/29 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ..... 191..., to ..... 191...
~~that I last saw h~~ ..... ~~alive on~~ ..... 191...,
~~and that~~ death occurred on the date stated above, at 2 30 P M.

The CAUSE OF DEATH* was as follows:
Suicide
by Gun Shot
(Coroners Verdict)
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred K Brown M. D.
19... (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: June 22 1914

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2010
Primary Registration District No. 1010
File No. 8092
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. Edward Ludrick
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 14 (Day) 1846 (Year)

7. AGE: 74 yrs. 9 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Ludrick

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Ludrick
(Address) Emmett Idaho

15.
Filed 6/14 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191 , to — 191
that I last saw h alive on — 191 ,
and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Probably acute heart failure or apoplexy. Did not see him alive.
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
May 9 1914 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos ds. In the State yrs mos ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery — DATE OF BURIAL: May 10 1914

20. UNDERTAKER: C. O. Brennan — ADDRESS:

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

Form V. S. No. 5. [illegible]. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2010
Primary Registration District No.
(No. , St.)

File No. 8093
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Margaret A. Davidson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 6 (Day) 1884 (Year)

7. AGE: 30 yrs. 2 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John M. Good

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Isabelle Morrow

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Davidson
(Address) Emmett Idaho

15.
Filed 6/29 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1914, to — 191..
that I last saw h— alive on — 191..,
and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Gunshot wound entering the precordial region terminating at the angle of the right scapula
— (Duration) —yrs. —mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) L. N. Cummings M. D.
6/27 1914 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Drexel Mo
DATE OF BURIAL: Don't Know 191..

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8094

Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2010
Primary Registration District No.
(No. ....., ... St.)

2. FULL NAME Joseph D. Campbell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1851 (Year)

7. AGE: 63 yrs. 1 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Thomas Campbell

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Elizabeth Davis

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Tom Campbell
(Address): Emmett Idaho

15.
Filed 6/29 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Autumn 1913, to June 19 1914 that I last saw him alive on June 17 1914, and that death occurred on the date stated above, at 2. P. M.

The CAUSE OF DEATH* was as follows:

Lympho-Sarcoma

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) Pneumonia Contrac

(Duration) Several yrs. ..... mos. ..... ds.

(Signed) R N Cummings M. D.

June 19 1914 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: June 21 1914

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8095
Registered No.

1. PLACE OF DEATH. Registration District No. 53
County of Bear Lake Primary Registration District No. 2132
City of Lanark (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wanda Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fml
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: ~~May~~ (Month) 15 (Day) 1914 (Year)
7. AGE: ..... yrs. ..... mos. 31 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Lanark
10. NAME OF FATHER: Owen Roberts
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Maryann Watkins
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Roberts
(Address) Lanark Idaho
15.
Filed 6/29/ 1914 B. J. Sullivan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 18 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from — 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 11:10 P. M.
The CAUSE OF DEATH* was as follows:
I think Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Don't know
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr. Cache Roberts M. D.
19..., (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lanark | DATE OF BURIAL: 6/21/ 1914
20. UNDERTAKER: F Passey | ADDRESS: Lanark

Owen Roberts child's name

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.2-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8001

Registered No. 7

1. PLACE OF DEATH. Registration District No. 353

County of Bear Lake Primary Registration District No. 2132

City of Lanark (No. ; St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Married

6. DATE OF BIRTH: June (Month) 27 (Day) 1833 (Year)

7. AGE: 81 yrs. 11 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Hubbard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Smith

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John S Parker
(Address) Paris

15. Filed 6/29/ 1914 R. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h[illegible] alive on ..... 191...,
and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:
Heart Insufficiency
(Duration) 3 yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) John S Parker M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Liberty	6/ 1/ 1914

20. UNDERTAKER	ADDRESS
Bishop & Tassey	Lanark Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Bureau of Vital Statistics

County of Bonner — Primary Registration District No. 215 — File No. 809

City of Sandpoint (No. ....., ... St.) — Registered No. 317

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rufus N. Graves.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 8 (Day) 1821 (Year)

7. AGE: 92 yrs. 11 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. Graves.
(Address) Laclede Idaho.

15. Filed 3/3 1914 — Mark Kinnear, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26 1914, to Feb. 28 1914 that I last saw him alive on Feb. 28 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Old age.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert A. Allen M. D.

April 29 1914 (Address) Laclede Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Laclede Idaho. DATE OF BURIAL: 3/3 1914

20. UNDERTAKER: E. M. Brower ADDRESS: S.P.

N. B.—Every item of information should be stated EXACTLY. PLACE and DATE OF BIRTH, AGE should be stated CAUSE OF DEATH should state CAUSE OF DEATH so that it may be properly classified. Exact ment of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INK. DO NOT USE PENCIL. THIS IS A PERMANENT RECORD.

MARGIN FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 7155

File No. 8099

County of Bonner

City of Glengary (No. ....., ... St.)

Registered No. 579

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J Christian Wildfang

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Widower

6. DATE OF BIRTH: Jan 23 (Month) 1829 (Day) (Year)

7. AGE: 85 yrs. 3 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or establishment in which employed (or employer): retired

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: J. C. Wildfang

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Mari Smitto

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Martin
(Address) .....

15. Filed 6/20 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1914, to May 9 1914, that I last saw him alive on May 7 1914, and that death occurred on the date stated above, at 8 1/2 P.M.

The CAUSE OF DEATH* was as follows:
Senile Debility

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas S Moody M. D.

May 12 1914 (Address) Hope Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hope — DATE OF BURIAL: May 12 1914

20. UNDERTAKER: E McBrown — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonner 6 — Registration District No. 78

City of Sandpoint — Primary Registration District No. 2153

(No. ....., ... St.)

File No. 8100

Registered No. 521

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ana Frank

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: October 15 (Month) (Day) 1866 (Year)

7. AGE: 47 yrs. 7 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Mick Hubert

11. BIRTHPLACE OF FATHER (State or Country): Bavarian Germany

12. MAIDEN NAME OF MOTHER: Josephine

13. BIRTHPLACE OF MOTHER (State or Country): Bavaria Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John E Frank
(Address): Sandpoint

15.
Filed 6/20 1914 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1914, to May 15 1914
that I last saw her alive on May 15 1914,
and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Heart Failure - following Pneumonia
Found dead in bed.
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) M McKinnon M. D.
June 1 1914 (Address) Sandpoint Ida

*Give the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Park Falls Wis. — DATE OF BURIAL: 5/18 1914

20. UNDERTAKER: E M Brower — ADDRESS: [illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 76

Primary Registration District No. 2167

File No. 5101

County of Bonner.

City of Sandpoint. (No. ....., ... St.)

Registered No. 520

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Swan Swanson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

58 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Filer.

(b) General nature of industry business, or dstablishment in which employed (or employer) Woods.

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Swanson

(Address) Sandpoint Ida

15.

Filed 6/20 1914 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May. (Month) 12. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Knapp M. D.

5/17 1914 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	May 14 1914

20. UNDERTAKER	ADDRESS
E M Brower	S P

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Ont.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Kootani
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

File No. 8102
Registered No. 522
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis W Edgert.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	married

6. DATE OF BIRTH
May (Month) 28 (Day) 1878 (Year)

7. AGE
35 yrs. 11 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Monroe
(Address) Kootenai, Idaho

15.
Filed 6/20 1914 Monroe Kininmonth
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1914, to May 24th 1914, that I last saw h(er) alive on on May 23 1914 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral haemorrhage

(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Chronic nephritis
(Duration) Several yrs. ..... mos. ..... ds.

(Signed) E W Pearson M. D.
May 25 1914 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint | DATE OF BURIAL: May 25 1914

20. UNDERTAKER: E M Brower | ADDRESS: L. P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
...y item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
...NS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
...ent of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8104
Registered No. 5 24

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2167
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Edward Murphy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: May 29 1848 (Month) (Day) (Year)

7. AGE: 66 yrs. 2 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. H. Gray
(Address) Sandpoint

15.
Filed 6/20 1914
M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 30 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1914 to June 1 1914 that I last saw h[illegible] alive on May 30 1914 and that death occurred on the date stated above, at 11-9 M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) 5 yrs. — mos. — ds.
Contributory (Secondary) Repeated attacks
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Jamison M. D.
June 4 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: May 31 1914

20. UNDERTAKER: E M Brower
ADDRESS: [illegible]

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8105
Registered No.

1. PLACE OF DEATH.
Registration District No.
County of Bonner
Primary Registration District No.
City of Copeland Ida. (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Krause Sr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 15th (Day) 1912 (Year)

7. AGE: 1 yrs. 11 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Copeland Ida.

10. NAME OF FATHER Robert Krause

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Meller

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Krause
(Address) Copeland Ida

15. Filed June 17 1914 E. E. Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 4 30 P. M.

The CAUSE OF DEATH* was as follows:
Drowning
(accidental)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fox M. D.
6/17 1914 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Copeland Ida — DATE OF BURIAL: 6/17 1914

20. UNDERTAKER: C. T. Moore — ADDRESS: Bonners Ferry Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8106

Registered No.

1. PLACE OF DEATH.

County of Bonner Registration District No.

City of Bonners Ferry (No.) (St.) Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Richard Dobson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July 16th 1910. (Month) (Day) (Year)

7. AGE: 3 yrs. 11 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Joseph S Dobson

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Mary Buchan

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Dobson
(Address) Naples Idaho

15.
Filed June 28th 1914. E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 28th 1914. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1914 to June 28 1914, that I last saw him alive on June 27 1914, and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

..... (Duration) ..... yrs. ..... mos. 11 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

6/28 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paradise Valley

DATE OF BURIAL: 6/29 1914

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 810

Registered No.

1. PLACE OF DEATH.

Registration District No.

County of Bonneville

Primary Registration District No.

City of Bonneville Ferry (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlie Leppell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH

..... (Month) 1 (Day) ..... (Year)

7. AGE

..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed July 2nd 1914 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 1st 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Gunshot wound -
(of heart) (homicidal)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

7/2 1914 (Address) Bonneville Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonneville Ferry — DATE OF BURIAL: July 3 1914

20. UNDERTAKER: John I Moore — ADDRESS: Bonneville Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. Country Hospital St.)

File No. 4810

Registered No. 184

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Cain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed June 3rd 1914

O. J. Keefe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... June (Month) ..... 1 (Day) ..... 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1914, to June 1 1914, that I last saw him alive on June 1 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hemorrhage, cerebral, into left lateral ventricle.

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Newton M. D.

June 3 1914. (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 6/3 1914

20. UNDERTAKER: H. H. Walker Undertaking Co. — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE-YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8114

Registered No. 185

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 647 N 6 Ave St.)

Registration District No. 84

Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arnold Leonard Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 13 (Day) 1903 (Year)

7. AGE: 10 Yrs. 5 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER W. D. Nelson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Claudia Hamson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. C. Hamson

(Address) Pocatello, Idaho

15. Filed June 5th 1914 — O. J. Seacy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1914, to June 4 1914, that I last saw him alive on June 4 1914, and that death occured on the date stated above, at 11:25 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilitation of heart

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Pleurisy with effusion

(Duration) yrs. mos. 5 ds.

(Signed) A. M. Newton M. D.

June 4 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Draper Utah — DATE OF BURIAL: 1914

20. UNDERTAKER: R. C. Walker Undertaking Co. — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BOOKS. 24858

29

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of near Pocatello. (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84.
Primary Registration District No. 2161

File No. 4
Registered No. 18811

2. FULL NAME E W Doss

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1829 (Year)

7. AGE: 84 yrs. 8 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: John Doss

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Margerite Summerfield

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marie D. Lyon
(Address) Near Pocatello

15. Filed July 1, 1914 O F Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 '14 1914 to June 27 '14 1914, that I last saw him alive on June 27 '14 1914 and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Oedema

(Duration) ____ yrs. 1 mos. 2 hours ds.
Contributory (Secondary): Nephritis
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. A. Castle M. D.
June 29" 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View | DATE OF BURIAL: ____ 191

20. UNDERTAKER: Crawford & Schumacher | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8114

Registered No. 167

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. Country hospital St.)

Registration District No. 84.

Primary Registration District No. 216

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Gleason

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. (Month) (Day) (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

Information to be Obtained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....

(Address) ....

15. Filed 5-7-1914 O R Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191.... to ....191....
that I last saw h.... alive on May 2 1914
and that death occured on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Rocky Mountain Spotted Fever

....(Duration) ....Yrs. ....mos. 14 ds.
Contributory (Secondary) Myocarditis
....(Duration ....yrs. ....mos. ....ds.
(Signed) Dr A M Newton M. D.
....19.... (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cemetary	5/4 1914
20. UNDERTAKER	ADDRESS
Ed Walker Undertaking Co	Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4811

Registered No. 16

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. 6th Ave.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Carr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Own Account

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed May 7 1914 ..... O F Keeley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h...alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun shot wound.

Suicide

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) O F Keeley M. D.

5-2-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Mt View Cemetery	5/8 1914
20. UNDERTAKER	ADDRESS
The Walker Undertaking Co.	Pocatello Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock
City of Pocatello

Registration District No. 84.
Primary Registration District No. 2161
(No. ..... 6th Ward)

File No. 4 8115
Registered No. 169

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Thayer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH.

Oct (Month) 17 (Day) 1 (Year)

7. AGE

..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER — Beck

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. M. Thayer

(Address) Ontario Ore.

15.

Filed May 7, 1914 O. P. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to May 2 1914, that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun shot wound - Homicide.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. P. Lewis Coroner M. D.

5-2- 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — Mt View Cemetary — DATE OF BURIAL May 6 1914

20. UNDERTAKER — Thos Walker Undertaking — ADDRESS Pocatello Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOX. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 4811
Registered No. 170

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Meyers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. (Month) (Day) (Year) 1

7. AGE: 30 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor Painter & Glazier
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER
Mothers name is Mary Meyers

13. BIRTHPLACE OF MOTHER (State or Country)
2358 Howard St. San Francisco Cal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address)

15. Filed 5-7- 1914
O B Seely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1914, to May 3 1914, that I last saw him alive on May 3 1914, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) 4 months mos. ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.

(Signed) Dr A M Newton M. D.
19 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 5/8 1914

20. UNDERTAKER: Walker Undertaking Co — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM No. 8. No. 1276 M. 1-15-13.

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. [illegible] Carey St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B Thayer

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4 8117

Registered No. 171

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. Oct (Month) 23 (Day) 1875 (Year)

7. AGE: 38 Yrs. 6 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Engineer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pa

10. NAME OF FATHER Corydon E Thayer

11. BIRTHPLACE OF FATHER (State or Country) Pa

12. MAIDEN NAME OF MOTHER Hester R. Allen

13. BIRTHPLACE OF MOTHER (State or Country) Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Archie O Thayer

(Address) Lolo Mont

15. Filed 5-7-1914 O B Lucy Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...;

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Homicide

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) O B Lucy M. D.

5-7-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: May 6 1914

20. UNDERTAKER: The Walker Undertaking Co — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock — Registration District No. 94.

City of Pocatello — Primary Registration District No. 2161

(No. .... St.)

File No. 811 4

Registered No. 172

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ansel Crosby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 5-11-1914 — O B Sears, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191✓, to May 9 1914, that I last saw h✓ alive on ✓ 191✓ and that death occured on the date stated above, at 7.30 a M.

The CAUSE OF DEATH* was as follows:

Accident— R R

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O B Sears M. D.

5/9 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milford Utah — DATE OF BURIAL ..... 191....

20. UNDERTAKER: Wm Walker Undertaking Co — ADDRESS: Pocatello Ida

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of ..... (No. ....., ... St.)
File No. 4911
Registered No. 173.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Louise Thacker

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 1st 1854 (Month) (Day) (Year)

7. AGE: 60 yrs. 2 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Housework
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Richmond Virg

10. NAME OF FATHER: Dickerson

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Tate

13. BIRTHPLACE OF MOTHER (State or Country): Richmond Vir

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. C. Thacker
(Address) Conystal

15. Filed May 14 1914 O. B. Heiny Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 13 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidents Fell off Header
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. B. Heiny Coroner M. D.
5-14-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Crystal Cem	May 15 1914

20. UNDERTAKER	ADDRESS
Crawford and Schumacher	Pocatello Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 849
Primary Registration District No. 2761.
File No. 812
Registered No. 144

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 322, N. 6th Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Merton F. Coffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May 11 1914
(Month) (Day) (Year)

7. AGE
— Yrs. — Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: W. B. Coffin

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER: Anna M. Johnson

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. B. Coffin
(Address) .....

15.
Filed May 15, 1914
O. P. Stacy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 14th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1914, to May 14 1914, that I last saw h... alive on May 13 1914, and that death occured on the date stated above, at 8.30 A.M.

The CAUSE OF DEATH* was as follows:
Influenza
.....
.....
(Duration) ..... Yrs. ..... mos. 2 1/2 ds.
Contributory (Secondary) Premature birth
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. May M. D.
5.14.1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey Idaho
DATE OF BURIAL: .....191...

20. UNDERTAKER: The Walker Undertaking Co.
ADDRESS: Pocatello Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M... 16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 8124
Registered No. 178

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 654, N Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James Graham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. February (Month) 23rd (Day) 1847 (Year)

7. AGE: 67 Yrs. 2 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Robert Graham

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Daup Knox

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miss J. M. Graham
(Address) Pocatello Ida.

15. Filed May 16th 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on May 15th 1914,
and that death occured on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
Aortic regurgitation

(Duration) 18 Yrs. ... mos. ... ds.
Contributory (Secondary): Unknown
(Duration ... yrs. ... mos. ... ds.

(Signed) H A Castle M. D.
May 19 14 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Evanston Wyo. DATE OF BURIAL: May 191 4

20. UNDERTAKER: The Walker Undertaking Co ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 4 8122

County of Bannock

City of Pocatello (No. Gen Hospital St.)

Registered No. 176.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William O'Fleming

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: May 18th 1858 (Month) (Day) (Year)

7. AGE: 56 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stone Mason
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: James Fleming

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bazil Jones

(Address) Cor Pocatello

15. Filed May 18 1914 O B Leedy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 18 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1914, to May 18 1914, that I last saw h/m alive on May 18 1914 and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) 2 yrs. — mos. 3 ds.

Contributory (Secondary) Nephritis

(Duration) Few yrs. — mos. — ds.

(Signed) W. J. Howard, M. D.

5/18/1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. — mos. 1/2 days. In the State. 10 yrs. ... mos. ... days.

Where was disease contracted if not at place of death? Cruise ranch

Former or usual residence Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: May 20 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161.
File No. 4912
Registered No. 178.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 303 N. Lincoln St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Doolittle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH: May 19 (Month) (Day) 1914 (Year)

7. AGE: Infant yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: L O Doolittle

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: A E Lang

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L O Doolittle
(Address) 303 N. Lincoln

15. Filed May 21, 1914 O J Heacock Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 20th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1914, to May 20 1914 that I last saw him alive on May 20 1914 and that death occurred on the date stated above, at 10a.m.

The CAUSE OF DEATH* was as follows:
Premature Birth 7 mos

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) W J Howard M. D.
5/20 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: May 21 1914

20. UNDERTAKER: Crawford & Schumacher — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84.
Primary Registration District No. 2161
File No. 9124
Registered No. 179

1. PLACE OF DEATH.
County of Bonneville
City of Pocatello
(No. 420 W. Whitman St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel C McFadden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 21 (Day) 1914 (Year)

7. AGE: 56 Yrs. 10 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Benj F. Chilson

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: T. Hoag

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J W McFadden
(Address) 420 W. Whitman St. Pocatello Idaho.

15. Filed May 27 1914 O P Auer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1914, to May 21 1914, that I last saw her alive on May 21 1914 and that death occured on the date stated above, at 4 p M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary): Arterio Sclerosis

(Duration) Yrs. mos. ds.

(Signed) W. J. Hamant M. D.

5/23 1914 (Address) Pocatello Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: May 23 1914

20. UNDERTAKER: Thos Walker Undertaking Co — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 345 N. Hayes St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
File No. 4 912
Registered No. 180
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John D. Hopson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH: June 30th 1860 (Month) (Day) (Year)

7. AGE: 53 yrs. 10 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Attorney
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: John D. Hopson

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Eliza Clark

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.F. Hopson
(Address) 345 N Hayes St

15. Filed May 23 1914 O.P. Stevens Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 21 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1914, to May 21 1914, that I last saw him alive on May 21 1914, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Liver

(Duration) One yrs. — mos. — ds.
Contributory (Secondary) Multiple secondary Carcinoma

(Duration) — yrs. few mos. — ds.

(Signed) W. H. Howard M. D.
5/22 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clayton Repas | DATE OF BURIAL: May 26 1914

20. UNDERTAKER: Crawford and Schumacher | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 4127
Registered No. 181

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Castle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept (Month) 19 (Day) 1834 (Year)

7. AGE: 79 Yrs. 8 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Brown

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M Castle
(Address) Pocatello Idaho

15. Filed May 25th 1914
O P Lewis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 23rd (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18" 1914, to May 23" 1914, that I last saw her alive on May 23" 1914, and that death occured on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 20 Yrs. mos. ds.
Contributory (Secondary) Exposure
(Duration yrs. mos. 7 ds.
(Signed) M Castle M. D.
May 25 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: May 26 1914

20. UNDERTAKER: KER UNDERTAKING CO. — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SONS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 512-4
Registered No. 182

1. PLACE OF DEATH.
County of Bannock
City of ½ Mile West of Onyx (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME [illegible]

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Section Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed May 26th 1914 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 12:02 P.M.
The CAUSE OF DEATH* was as follows:
R. R. Accident.
Run over on track
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. B. Healy Coroner M. D.
5-26 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: May 27 1914

20. UNDERTAKER — ADDRESS: Pocatello Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 5124
Registered No. 193

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jno Rogers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Unable to obtain

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed May 29, 1914 ..... Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 27 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1914, to May 27 1914, that I last saw him alive on May 26 1914, and that death occured on the date stated above, at 1.30 A M.

The CAUSE OF DEATH* was as follows:
Surgical shock
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Crushing injury to Rami & Leg
.....(Duration ..... yrs. ..... mos. ..... ds.
5/27 1914 (Signed) E. E. Roberts M. D.
(Address) Pocatello Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: May 27 1914

20. UNDERTAKER: Chas Walker Undertaking — ADDRESS: Pocatello

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 2130
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pearl Harstad

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F	White	Mar (Write the word.)

6. DATE OF BIRTH
Jan 18 (Month) (Day) 1886 (Year)

7. AGE
30 yrs. 4 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Minn

10. NAME OF FATHER Hiram Schlotte

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Lidia Overholser

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Olmi Harstad
(Address) Twin Falls Ida

15.
Filed 6-15 1914 John T. Cogdell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1" 1914, to June 13 1914
that I last saw h[illegible] alive on June 13 1914
and that death occurred on the date stated above, at 11.55 M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) ..... yrs. ..... mos. 13 ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Boyd M. D.
June 15 1914 (Address) Dr Boyd

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Twin Falls — DATE OF BURIAL June 15 1914

20. UNDERTAKER Thos J Crosby — ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 9131
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. Gales Gilbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
June (Month) 20 (Day) 1842 (Year)

7. AGE
71 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Scenic artist
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Wm. D. Gilbert

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Mary Hurtle

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Amelia Gilbert
(Address) Twin Falls,

15.
Filed June 7 1914 John H. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21— 1914, to June 5 1914
that I last saw him alive on June 5— 1914
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 14 yrs. — mos. — ds.
Contributory (Secondary) Endocarditis
(Duration) 7 yrs. — mos. — ds.

(Signed) Frank A. Dwight M. D.
June 6 1914 (Address) Twin Falls. Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Twin Falls | DATE OF BURIAL June 7 1914

20. UNDERTAKER J. F. Grossman ADDRESS Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ....., ... St.)

File No. 8132
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grace Rider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	Wh.	

6. DATE OF BIRTH
Jan. 18th 1891
(Month) (Day) (Year)

7. AGE
23 yrs. 4 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Twin Falls

10. NAME OF FATHER
Geo. W. Rider

11. BIRTHPLACE OF FATHER
(State or Country) Canada

12. MAIDEN NAME OF MOTHER
Ida Hutchinson

13. BIRTHPLACE OF MOTHER
(State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. W. Rider
(Address) Twin Falls. Ida. R.F.D.

15.
Filed June 11 1914 Johnd Coghlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 10 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1914, to June 10 1914, that I last saw her alive on June 9th 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Long M. D.
June 11 1914 (Address) Twin Falls. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 6-11 1914

20. UNDERTAKER: Chas. J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 8133
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Murtaugh (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward W. Gordan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	Wht.	

6. DATE OF BIRTH: June (Month) 10 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Twin Falls County

10. NAME OF FATHER Bruce E. Gordan

11. BIRTHPLACE OF FATHER (State or Country) Colo

12. MAIDEN NAME OF MOTHER Blanche E. Young

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. J. Crosby
(Address) .....

15. Filed 6-15 1914 John T. Coughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1914, to June 14 1914, that I last saw him alive on June 14 1914 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Marasmus

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Gordon M.D.
(Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Murtaugh DATE OF BURIAL: June 15 1914

20. UNDERTAKER: C. J. Crosby ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 8134
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
(No. 516, 5th Ave North St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME R. L. Fryar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: June (Month) 13 (Day) 1914 (Year)

7. AGE: ____ yrs. ____ mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER G. R. Fryar

11. BIRTHPLACE OF FATHER (State or Country) Mississippi

12. MAIDEN NAME OF MOTHER Nell Scott

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. R. Fryar
(Address) Twin Falls

15. Filed June 21 1914 John T. Cowden Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1914, to June 20 1914, that I last saw h[im] alive on June 20 1914, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Meningitus

(Duration) ____ yrs. ____ mos. 7 ds.

Contributory (Secondary) Forceps Delivery

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. R. Morgan M. D.
June 20 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 6-21 1914

20. UNDERTAKER: P. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STNRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 135

Registered No. 15

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 2199.

2. FULL NAME Della Briggs

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 16. 1898
(Month) (Day) (Year)

7. AGE: 16 yrs. 3 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Harvey L. Briggs

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Cordelia Lovett

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey Briggs
(Address) Oakley Idaho

15.
Filed 7/10 1914 E P Oldham
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 27 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1914, to June 1914, that I last saw h[illegible] alive on June 16 1914, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. mos. ds.

Contributory (Secondary) Secondary Infection

(Duration) 6 yrs. mos. ds.

(Signed) E P Oldham M. D.
June 28 1914 (Address) Oakley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Marion Idaho	June 28 1914

20. UNDERTAKER	ADDRESS
James B Whitby	Marion Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Basin
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 2199
(No. ....., ... St.)

File No. 8136
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachel M Wells

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1844 (Year)

7. AGE: 73 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER John White

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER — Crowley

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Wells
(Address) Rt 1 Box Idaho

15. Filed 7/10 1914 E P Oldham
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1913, to June 1914, that I last saw her alive on Dec. 1913, and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus
Maisded

(Duration) ..... yrs. 10 mos. ..... ds.
Contributory (Secondary) Irregular Hock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
6/23 1914 (Address) E P Oldham

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basin Idaho
DATE OF BURIAL: 6-25 1914

20. UNDERTAKER: A. Sayers
ADDRESS: Basin

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Green Creek
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2781
(No. ....., ... St.)

File No. 813
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elisabeth Westhoff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F	W	widow

6. DATE OF BIRTH
Don't Know (Month) 1 (Day) ..... (Year)

7. AGE
73 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER [illegible]

11. BIRTHPLACE OF FATHER (State or Country) [illegible]

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (State or Country) [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev J J Baerlocher
(Address) Green Creek Ida

15.
Filed July 2 1914 G S Sluckin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
senile decay

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory unknown
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rev J J Baerlocher ~~M. D.~~
6/26 1914 (Address) Green Creek Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Green Creek Ida	6/27 1914
20. UNDERTAKER none	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 2181

File No. 13

Registered No. 25

County of Idaho

City of Green Creek (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gaspar Hunzel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Don't Know (Month) (Day) 1 (Year)

7. AGE: 76 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: [illegible] Hunzel

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev J J Baerlocher

(Address) Green Creek Idaho

15. Filed July 2 1914 G B Stricklin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senile decay

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rev J J Baerlocher M. D.

6/6 1914 (Address) Green Creek Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green Creek Ida — DATE OF BURIAL: 6/7 1914

20. UNDERTAKER: None — ADDRESS:

SYMS - YORK CO., PTRS. & BDRS. 19750

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 914
Registered No. 20

1. PLACE OF DEATH.
County of Idaho
City of Idaho Co. Farm (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Copeland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Single

6. DATE OF BIRTH Don't Know 1
(Month) (Day) (Year)

7. AGE 68 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Beyer
(Address) County Farm

15. Filed July 2 1914 G S Sleeth
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 1 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1914 to July 1 1914
that I last saw him alive on June 30 1914
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Valvular lesion of heart
(Duration) Don't Know yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) G S Sleeth M. D.
July 1 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grangeville	July 1 1914
20. UNDERTAKER	ADDRESS
E S Hancock	Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 103
Primary Registration District No. 2181
(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8141
Registered No. 19

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Not for Record

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 6 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many 17 hrs. or 90 min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Jim O'Keefe

11. BIRTHPLACE OF FATHER (State or Country): Davidson, Missouri

12. MAIDEN NAME OF MOTHER: Nellie Williams

13. BIRTHPLACE OF MOTHER (State or Country): Yabet Co Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jim O'Keefe
(Address) Grangeville Ida

15. Filed July 2 1914 G S Stretton Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1914, to June 7 1914, that I last saw h[illegible] alive on June 7 1914, and that death occured on the date stated above, at 5:00 P.M.
The CAUSE OF DEATH* was as follows:

Hemorrhage of foramen ovale

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Warner M. D.
(Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grangeville Ida — DATE OF BURIAL: June 7 1914

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

Primary Registration District No. 2177

File No. 814

County of Fremont

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lester Dewain Durney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	single

6. DATE OF BIRTH

May (Month) 16 (Day) 1914 (Year)

7. AGE

..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..16½.. hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... None .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ashton Ida

10. NAME OF FATHER Miles Durney

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Arabelle Wetherbee

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Caufield

(Address) St. Anthony

15.

Filed July 9 1914. W. A. Ewer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1914, to May 16 1914 that I last saw him alive on May 16 1914, and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ..... yrs. ..... mos. 2/3 ds.

Contributory (Secondary) Status gestation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Caufield M. D.

5-18 1914 (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ora Ida — DATE OF BURIAL: May 19 1914

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

County of Bannock

Primary Registration District No. 2177

File No. 8143

City of St Anthony (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mildred Birch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	single

6. DATE OF BIRTH

June (Month) 1 (Day) 1914 (Year)

7. AGE

..... yrs. ..... mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... none .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) St Anthony Ida

10. NAME OF FATHER Melvin Birch

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Rosabella Smith

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Mayfield

(Address) St Anthony

15. Filed July 9 1914 W Olwell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1914, to June 20 1914, that I last saw her alive on June 20 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale and Pulmonic Stenosis

(Duration) ..... yrs. ..... mos. 25 ds.

Contributory .....

(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Mayfield M. D.

6 27 1914 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Walford — DATE OF BURIAL Jun 27 1914

20. UNDERTAKER T Moore — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99

Primary Registration District No. 2177

File No. 8144

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Potter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH
Dont Know (Month) (Day) 183[illegible] (Year)

7. AGE
82 yrs. ____ mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) ____

9. BIRTHPLACE Utah (State or Country)

10. NAME OF FATHER Millross

11. BIRTHPLACE OF FATHER Dont Know (State or Country)

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER Dont Know (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H C Potter
(Address) Chester Idu

15. Filed July 9th 1914 W D Swett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 27 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16th 1914, to June 10 1914, that I last saw h[illegible] alive on June 10 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Senile Gangrene

(Duration) ____ yrs. 2 mos. ____ ds.
Contributory Old Age
(Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W D Swett M. D.
6 28 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL Teton City
DATE OF BURIAL June 29 1914

20. UNDERTAKER None
ADDRESS ____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 815
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of Saint Parker (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lola Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1908 (Year)

7. AGE: yrs. 5 mos. 15 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Parker Idaho

10. NAME OF FATHER: Alvin S Jackson

11. BIRTHPLACE OF FATHER (State or Country): Cache Co Utah.

12. MAIDEN NAME OF MOTHER: Effie Mangum

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles M. Jackson
(Address) Parker Idaho

15. Filed July 1th 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 28 1914, to May 10 1914, that I last saw her alive on May 6 1914, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Bronchitis

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A Morfield M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker
DATE OF BURIAL: May 12 1914

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 2146
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Angeline Margaret Bell

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Aug (Month) 16 (Day) 1913 (Year)

7. AGE: ..... yrs. 10 mos. 30 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Samuel Bell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Malnee Cur

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Bell
(Address) Canyon Creek Ida

15. Filed July 9th 1914 W. D. Lloyd Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1914, to July 6 1914, that I last saw her alive on July 6 1914, and that death occurred on the date stated above, at 10.30 A. M.

The CAUSE OF DEATH* was as follows:
Hydrocephalus

(Duration) ..... yrs. ..... mos. 14 ds.
Contributory (Secondary) Meningitis
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) W. D. Lloyd M. D.
July 7 1914 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford Ida — DATE OF BURIAL: July 8 1914

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 44
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 3 814
Registered No. 394
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Jane Preston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~SINGLE, MARRIED, WIDOWED~~ OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: October 13" 1859 (Month) (Day) (Year)

7. AGE: 55 yrs. 8 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWL[redacted]
(Informant) Mrs. Mattie Boh[redacted]
(Address) Loon Lake Wash[redacted]

15. Filed June 15 1914 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June - 14" 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29" 1914, to June 14 1914 that I last saw her alive on June 14" 1914, and that death occurred on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:
Adeno carcinoma of Uterus
First Recognized Jan. 16-1914

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Complete Anuria

(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) C. B. Stratton M. D.
6/15 1914 (Address) Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery. DATE OF BURIAL: June 15" 1914

20. UNDERTAKER: J. C. Hoobler ADDRESS: Salmon

Paa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 14
Registered No. 40

1. PLACE OF DEATH.
County of Lemhi
City of Junction
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
53 September 8 1860
(Month) (Day) (Year)

7. AGE
53 yrs. 9 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Ranching
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Geo. W. Clark

11. BIRTHPLACE OF FATHER (State or Country) Maryland

12. MAIDEN NAME OF MOTHER Susan A. Stephenson

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John C[illegible]
(Address) Junction Idaho

15.
Filed June 24 1914 Helen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 31 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1914, to May 31 1914
that I last saw h[illegible] alive on May 31 1914
and that death occurred on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Acute nephritis
(Duration) About yrs. 2 mos. ..... ds.
(Signed) Chas. F. Hammel M. D.
June 2 1914 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Junction
DATE OF BURIAL: June 2 1914

20. UNDERTAKER: [illegible]
ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1716

Registration District No. 4 1

Primary Registration District No. 2116

1. PLACE OF DEATH.

County of Lemhi

City of Gibbonsville (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No. 41

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm B. Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Exact date not known 1847 (Month) (Day) (Year)

7. AGE: 67 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): would not work.

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. P. Hughes
(Address) Gibbonsville Ida

15. Filed June 17 1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 16 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1914 to June 1914 that I last saw her alive on June 5 1914 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
Chronic
(Duration) 6 yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Hammer M. D.
6/17 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? Here
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gibbonsville Ida. DATE OF BURIAL: June 17 1914

20. UNDERTAKER: E. E. Edwards Acting as Such ADDRESS: Gibbonsville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116

File No. 915
Registered No. 42
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Orville Billings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Feb 13" (Month) (Day) 1832. (Year)

7. AGE: 82 yrs. 4 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: [redacted] Billings

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Miss Pattridge

13. BIRTHPLACE OF MOTHER (State or Country): Ella Mayfield

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Salmon
(Address) Idaho

15. Filed July 7 1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 5" (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to July 5th 1914, that I last saw him alive on July 5th 1914, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary): old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Hebbeler M. D.
7/7 19 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR ~~REMOVAL~~: Salmon Cemetery — DATE OF BURIAL: 7-7" 1914
20. UNDERTAKER: W. C. Hebbeler — ADDRESS: Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BURS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

File No. 8151
Registered No. 43
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clowes D. Perkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not know (Month) 1 (Day) 1886 (Year)

7. AGE: 28 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Engineer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Not know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Doebler
(Address) Salmon Ida.

15. Filed July 8 1914 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF ~~DEATH~~: July 4th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1914, to July 4th 1914, that I last saw him alive on July 1st 1914, and that death occurred on ~~the date stated above~~ July 4th, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Emphysema

(Duration) ..... yrs. ~~2~~ mos. 19 ds.

Contributory (Secondary) Appendicitis

(Duration) ..... yrs. dont know mos. ..... ds.

(Signed) F. D. Wright M. D.
July 5 1914 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Salmon Cemetery | DATE OF BURIAL: July 8th 1914.

20. UNDERTAKER: W. C. Doebler | ADDRESS: Salmon Ida.

The doctor in this case was dealing with July 4th & Chester Smith's family employs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls — Registration District No. 38

City of Filer — Primary Registration District No. 2086 — (No. ..... St.)

File No. 152

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matilda Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. April (Month) First (Day) 1860 (Year)

7. AGE — 54 Yrs. 2 Mos. 11 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Toronto Canada

10. NAME OF FATHER D. Mccarroll

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mary Mccarroll

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. C. Stevens

(Address) Filer Idaho

15. Filed June 17 1914 — A A Newberry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — June (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1914, to June 11 1914, that I last saw h. alive on June 11 1914, and that death occured on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) A A Newberry M. D.

6/17 1914 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Filer Cemetery	6-13 1914

20. UNDERTAKER	ADDRESS
O J Crosby	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8153

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of .....

City of .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lloyd Allen Johnson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Aug (Month) 31 (Day) 1911 (Year)

7. AGE: 2 Yrs. 8 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Bronchial Pneumonia)

9. BIRTHPLACE (State or Country) Rupert Idaho

10. NAME OF FATHER W. R. Johnson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary L. Cook

13. BIRTHPLACE OF MOTHER (State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. R. Johnson
(Address) Rupert

15. Filed July 6 1914 — O. H. Scott, Local Registrar

SYMS - YORK CO., PRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1914, to May 15 1914, that I last saw h— alive on May 14 1914, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia following Bronchial Measles

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) C. A. Lemon M. D.

7-6 1914 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: May 16 1914

20. UNDERTAKER: W. G. Gordon — ADDRESS: Rupert

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8154

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie C Lemon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 3 (Day) 1856 (Year)

7. AGE: 58 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: dont Know

11. BIRTHPLACE OF FATHER (State or Country): dont Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ole Lemon
(Address) Rupert Ida

15. Filed July 6 1914 — P H Scott, Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24th 1914, to May 5th 1914, that I last saw h alive on May 5th 1914, and that death occured on the date stated above, at 5:00 M.

The CAUSE OF DEATH* was as follows:
Uraemic poison

(Duration) 2 Yrs. 2 mos. 3 ds.

Contributory (Secondary) Anes(aether) & abdom. Exploration for ventral Hernia (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Rowley M. D.

19..... (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: W. A. Goodman — DATE OF BURIAL: May 7 1914

20. UNDERTAKER: Rupert — ADDRESS: Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. [illegible] M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 815

Registered No.

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

Registration District No.

Primary Registration District No.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Coral Edna Deno

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Apr (Month) 11 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ed Deno

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Ellen Backman

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) John E. Anderson

15. Filed July 6 1914

Local Registrar C. H. Scott

SYMS - YORK CO., PORT. & BOS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11 — 1914, to Apr 11 — 1914, that I last saw her alive on Apr 11th 1914, and that death occured on the date stated above, at 4.00 P.M. or 5:30 AM

The CAUSE OF DEATH* was as follows:

Insufficiency of heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature delivery by 3 weeks

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Rowley M. D.

19..... (Address) Rupert, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Apr 12 1914

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2156

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Minidoka

City of Rupert (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lowen A Deno

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Boy

6. DATE OF BIRTH. Mar (Month) 17 (Day) 1900 (Year)

7. AGE: 14 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Fred A. Deno

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Edith S Hunter

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Fred A. Deno

15. Filed July 6 1914

O H Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: May 29 1914

20. UNDERTAKER: W. H. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 817
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy W Powers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 6 (Day) 1912 (Year)

7. AGE: 1 Yrs. 11 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Rupert Idaho

10. NAME OF FATHER A. J. Powers

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Jessie Edwards

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. J. Powers
(Address) Rupert,

15. Filed Jun 24 1914
O. H. Scott
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1914, to June 23 1914,
that I last saw him alive on June 23 1914,
and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) O. H. Scott M. D.
6/27 1914 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: 6-24 1914

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

61

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)

Registration District No. .....
Primary Registration District No. 1011

File No. .....
Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel E Curtis

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowe

6. DATE OF BIRTH: Nove 27 1837
(Month) (Day) (Year)

7. AGE: 78 yrs. 6 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or datablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Elbert Evens

11. BIRTHPLACE OF FATHER (State or Country): Cuntuckey

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chester L Curtis
(Address) Moscow

15.
Filed 6-17- 1914
J. N. Clarke
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 11 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1913, to June 11 1914, that I last saw h[illegible] alive on June 11 1914, and that death occurred on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:
Paralyses

(Duration) 1 yrs. 2 mos. 10 ds.
Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. M. Leitch M. D.
6/12 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 6/13 1914

20. UNDERTAKER: Geo Stitz
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

Primary Registration District No. 2141

File No. 815

Registered No. 41

County of Latah

City of Moscow (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles B. Towne

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1855 (Year)

7. AGE: 59 yrs. 5 mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ehlamer Towne

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Ellesta J Gail

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. Sherman Towne
(Address) Moscow

15. Filed June 5 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1914, to June 4 1914, that I last saw him alive on June 4 1914, and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

By Accident runaway team

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gustavus M. D.

June 5 1914 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 6/6 1914

20. UNDERTAKER: Geo Stolz — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 816
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary J Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: August 24 1841 (Month) (Day) (Year)

7. AGE: 73 yrs. 8 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): Waiter

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: John Williams

11. BIRTHPLACE OF FATHER (State or Country): North Wales

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Alonzo
(Address) Preston Idaho

15.
Filed June 26 191 Dr Allen Dueltz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 25 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 25 1914, that I last saw her alive on June 24 1914, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Herpes Zoster followed by septicaemia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): General debility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Guy Yates M. D.
June 26 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Franklin Co's
DATE OF BURIAL: June 27 1914

20. UNDERTAKER: W. A. Goldsmore
ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
County of Franklin
City of Fairview (No. ....., ... St.) Primary Registration District No. 2119
File No. 8161
Registered No. 32
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME E. H. Bronson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: August (Month) 22 (Day) 1851 (Year)

7. AGE: 63 yrs. 10 mos. —— ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah Saltlak Co.

10. NAME OF FATHER: C. D. Bronson

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Larisa Andrews

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Bronson
(Address)

15. Filed June 24 1914 D. Allen Russell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 22th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1914, to June 22nd 1914, that I last saw h.im alive on June 22nd 1914, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma descending colon

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) W. B. Parkinson Jr. M. D.

19..... (Address) Lewiston Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview | DATE OF BURIAL ..... 191...

20. UNDERTAKER: W. A. Skidmore | ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30 9162

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 97

Primary Registration District No. 2119

County of Franklin

City of Glendale (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willard Lamont

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH

June 5th 1914
(Month) (Day) (Year)

7. AGE

1 hr. yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Franklin Co Idaho

10. NAME OF FATHER Frank Lamont

11. BIRTHPLACE OF FATHER (State or Country) Preston Idaho

12. MAIDEN NAME OF MOTHER Ruth Bodily

13. BIRTHPLACE OF MOTHER (State or Country) Oxfordton

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. D Jensen

(Address) .....

15.

Filed June 6 1914 Dr Allen Rich
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1914, to Jun 5 1914, that I last saw h[illegible] alive on Jun 5 1914, and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. 45 minutes ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Slater M. D.

19[illegible] (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	June 6 1914

20. UNDERTAKER	ADDRESS
W. A. Smidmore	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 2112
City of Weiser (No. 15 N. E. of city St.)
File No. 816
Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Lena Bell Eveland

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH Jan — 9 — 1891
(Month) (Day) (Year)

7. AGE 23 yrs. 4 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) State of Missouri

10. NAME OF FATHER William Reason

11. BIRTHPLACE OF FATHER (State or Country) Philadelphia, Penn.,

12. MAIDEN NAME OF MOTHER Ella M. Sipple

13. BIRTHPLACE OF MOTHER (State or Country) Bucklin, Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eveland
(Address) Weiser

15. Filed June 3-d 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June — 2 — 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 191..., to June 2nd 1914, that I last saw h[illegible] alive on June 2 1914, and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of right hip joint.
(Duration) 6 yrs. 1 mos. — ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Carmen E. Conard M. D.
June 3rd 1914 (Address) Weiser, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Weiser — DATE OF BURIAL June 3-1914

20. UNDERTAKER A. G. Cordelle — ADDRESS Weiser,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 11.1
Registered No. 27

1. PLACE OF DEATH.
County of Washington
City of Weiser (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 56
Primary Registration District No. 1010

2. FULL NAME Miss Nina M. Foote

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: March (Month) 10 (Day) 1896 (Year)
7. AGE: 18 yrs. 3 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Servant
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): State of Missouri
10. NAME OF FATHER: Asa W. Foote
11. BIRTHPLACE OF FATHER (State or Country): State of Wisconsin
12. MAIDEN NAME OF MOTHER: Chloe Van Horsen
13. BIRTHPLACE OF MOTHER (State or Country): State of Iowa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Foote
(Address) Weiser, Ida.
15. Filed June 3rd 1914 W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 3 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 28 1914, to June 3 1914
that I last saw her alive on June 3 1914
and that death occurred on the date stated above, at 2.05 A M.
The CAUSE OF DEATH* was as follows:
Acute paranchymatous Nephritis
uril uremia

..... (Duration) ..... yrs. ..... mos. 8 ds.
Contributory Acute bichloride of mercury
(Secondary) Poison self administered through
..... (Duration) ..... yrs. ..... mos. 8 ds.
(Signed) C J Anderson M. D.
6/3 1914 (Address) Weiser

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser, Ida. DATE OF BURIAL: June 6 1914
20. UNDERTAKER: R. W. Bowen ADDRESS: Weiser, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8165
Registered No. 28

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 76
Primary Registration District No. 1010
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen J. Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: June (Month) 9 (Day) 1914 (Year)

7. AGE: 74 yrs. 11 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Stephen Smith

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Sarah J. Glasier

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank C. Smith
(Address) Weiser Idaho

15. Filed 6/10 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 8th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June — 1912 to June 8th 1914 that I last saw h[illegible] alive on June 8th 1914 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Intestinal

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Paralysis of muscles of throat
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.
6/10 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: L. C. Northern — ADDRESS: Weiser Ida.

ment of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1810
(No. ....., ... St.)

File No. 916
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John D. Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Wht	Single

6. DATE OF BIRTH: Oct. (Month) 4 (Day) 1890 (Year)

7. AGE: 23 yrs. 8 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: D. M. Roberts

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Lucy M Hommes.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Elizabeth L. Roberts
(Address) Woodbine, Iowa

15. Filed June 20th 1914 — W. R. Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1914, to June 18th 1914 that I last saw h[illegible] alive on June 17 1914 and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) 2 yrs. — mos. — ds.
Contributory (Secondary) Acute nephritis
..... (Duration) ..... yrs. ..... mos. 30 ds.

(Signed) Lawrence C. Lamont M. D.
6/20 1914 (Address) Weiser Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: 21 1914

20. UNDERTAKER: L. B. Northam — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 76
Primary Registration District No. 21126
(No. ....., ... St.)

File No. 41
Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Celesta Jane Brent

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 22 (Day) 1852 (Year)

7. AGE: 61 yrs. 11 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Geo. B. Shorter

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Miller

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Brent
(Address) Weiser

15.
Filed June 22nd 1914 — W R Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1913, to June 20 1914
that I last saw h[er] alive on June 20 1914
and that death occurred on the date stated above, at 9 33 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis.

(Duration) 5 yrs. — mos. — ds.
Contributory (Secondary): Myocarditis
(Duration) 5+ yrs. ..... mos. ..... ds.

(Signed) S. B. Dudley M. D.
6-22 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 9 22 1914

20. UNDERTAKER: L. L. Norton — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 1010
City of Weiser (No. ..... St.)
File No. .....
Registered No. 35 19.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Lena Holt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) — 20 (Day) — 1866 (Year)

7. AGE: 48 yrs. 1 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montpelier Idaho

10. NAME OF FATHER: Jens Jenson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. Holt
(Address) Weiser Idaho

15.
Filed 4/4 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) — 1 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1914, to May 1st 1914 that I last saw h— alive on May 1st 1914 and that death occurred on the date stated above, at 10 20 P. M.

The CAUSE OF DEATH* was as follows:
Accidental burns.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Epilepsy
..... (Duration) Several yrs. — mos. — ds.

(Signed) W. R. Hamilton M. D.
4/4/ 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser — DATE OF BURIAL: May 4 1914

20. UNDERTAKER: A. G. Cordelle — ADDRESS: Weiser

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S, No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9169
Registered No. 20

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 2112
City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George Washington Kiser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: February (Month) — 22 (Day) — 1856 (Year)

7. AGE: 64 yrs. 2 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of Ohio

10. NAME OF FATHER: Louis Kiser

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Nancy Floon

13. BIRTHPLACE OF MOTHER (State or Country): State Kiser

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charley Kiser
(Address) Council, Idaho

15.
Filed May 8th 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) — 7 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1913, to May 7 1914
that I last saw h.im alive on May 5 1914
and that death occurred on the date stated above, at 9 a. M.
The CAUSE OF DEATH* was as follows:
Mitral Insuffiency

..... (Duration) 1 yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) — yrs. — mos. ..... ds.
(Signed) James A Young M. D.
May 8 1914 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser, Ida. DATE OF BURIAL: May 9 1914

20. UNDERTAKER: R. W. Bowen ADDRESS: Weiser, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 2112
City of Weiser (No. ....., ... St.)
File No. 9170
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susannah Hall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH June (Month) 12 (Day) 1850 (Year)

7. AGE 63 yrs. 10 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Wm A Murray

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER McEntyre

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Hall
(Address) Weiser Idaho

15. Filed May 9th 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to May 8 1914
that I last saw her alive on May 8 1914
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart failure from
mitral regurgitation

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Mitchell M. D.
May 9 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sterling, Colo. DATE OF BURIAL ..... 191...

20. UNDERTAKER L. L. Northam ADDRESS Weiser Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. ....., ... St.)

File No. 811
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew P. Peterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 7 (Day) 1841 (Year)

7. AGE: 72 yrs. 4 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: ——

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willis Peterson
(Address) Weiser, Idaho

15. Filed May 12th 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1913, to May 12 1914 that I last saw him alive on May 12 1914 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

..... (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) Exhaustion

..... (Duration) ..... yrs. ^ mos. ..... ds.

(Signed) Ernest O. Fenner M. D.

May 12 1914 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser
DATE OF BURIAL: May 13 1914

20. UNDERTAKER: L. L. Northam
ADDRESS: Weiser Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8172
Registered No. 25

1. PLACE OF DEATH. Registration District No. 6
County of Washington Primary Registration District No. 2112.
City of Weiser (No. 17 N. E. of Weiser St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Susie Root

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH Nov. — 9 — 1858
(Month) (Day) (Year)

7. AGE 55 yrs. 6 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Los Angles, Calif.

10. NAME OF FATHER W. R. Fiddler

11. BIRTHPLACE OF FATHER (State or Country) State of Texas

12. MAIDEN NAME OF MOTHER Jenn. Tucker

13. BIRTHPLACE OF MOTHER (State or Country) State of Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Laura Root
(Address) City

15.
Filed May 21st 1914 W. R Runnells
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May — 18 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1913, to May 18, 1914, that I last saw her alive on May 4, 1914, and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:
Sudden no previous symptoms before death —
Embolism x
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Valvular Heart disease
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.
May 21, 1914 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Weiser Idaho — DATE OF BURIAL May 21 — 1914

20. UNDERTAKER R. W Bowen — ADDRESS Weiser

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 1010
City of Weiser (No. ..... St.)
File No. .....
Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Fronshall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 46 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Miner
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Mary Whelk

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emmett E. Fawcett
(Address) Weiser Ida.

15. Filed 5/29/14 191... W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 25 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver.

..... (Duration) 1 yrs. 2 mos. 2 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Emmett E. Fawcett M. D.
5/29 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weiser Ida	5/29/20 1914

20. UNDERTAKER	ADDRESS
L. L. Northam	Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

File No. 814

Registered No. 30

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margreat Winn.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb. (Month) 25 (Day) 1 (Year)

7. AGE: 50 yrs. 3 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sanpete Co. Utah.

10. NAME OF FATHER: Alec Adamson.

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Winn
(Address) Burley Idaho

15.
Filed June 6 1914 Dr. J. C Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-31- 1914, to 6-5- 1914 that I last saw her alive on June 5 1914 and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Septicemia

(Duration) ..... yrs. ..... mos. 2/ ds.

Contributory (Secondary) Empiritis

(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) A. J. Stone M. D.

19 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? Burley Idaho

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: June 8 1914

20. UNDERTAKER: L. B. Gascoigne ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. 9151

County of Cassia

City of Burley (No. ....., ... St.)

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Burnell Edwin Searle

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Single

6. DATE OF BIRTH: May (Month) 16th (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of w[illegible]
(b) General nature business, or dstablis[illegible] in which employed (or employer)

9. BIRTHPLACE (State or Country) Burley Idaho

10. NAME OF FATHER J. E. Searle

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary A. Moffett

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charley Moffett
(Address) Burley Ida.

15. Filed June 24th 1914 J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 22nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Ap[illegible] 191..., to ..... 191...,
that I last saw h[illegible] alive on ..... 191...,
and that death occurred on the date stated above, at 8.20 A.M.
The CAUSE OF DEATH* was as follows:
Probably Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. 2. ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley, Ida.	June 23rd 1914
20. UNDERTAKER	ADDRESS
None.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 911

Registered No. 30

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. 8th-st — St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Rufus Finnell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 4th Thursday 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 2½ ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: (Father) Common Labor.
(b) General nature of industry business, or dstablishment in which employed (or employer): Whites Dairy Co.

9. BIRTHPLACE (State or Country): Lewiston Ida. Nez perce Co.

10. NAME OF FATHER: Rufus Finnell.

11. BIRTHPLACE OF FATHER (State or Country): Belmont Wash.

12. MAIDEN NAME OF MOTHER: Myrtle Duncan.

13. BIRTHPLACE OF MOTHER (State or Country): Dayton Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rufus Finnell.
(Address) Lewiston Ida.

15.
Filed 7-10- 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 6th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1914, to June 6th 1914, that I last saw her alive on June 5 1914, and that death occurred on the date stated above, at 345 M.

The CAUSE OF DEATH* was as follows:
(Anurea) Traumatic from forceps.

..... (Duration) ..... yrs. ..... mos. 2½ ds.

Contributory (Secondary) Hemorrhage

..... (Duration) ..... yrs. ..... mos. 1½ ds.

(Signed) Edgar L. White M. D.

June 6 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: June 6 1914

20. UNDERTAKER: Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

File No. 91

City of Lewiston (No. North Lewiston St.)

Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry M. Porter,

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	Widower

6. DATE OF BIRTH: Sept 22 (Month) (Day) 1870 (Year)

7. AGE: 23 yrs. 8 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: John H. Porter

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Malinda McKinley

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Shanahan
(Address) Lewiston Idaho

15. Filed 7-10- 1914 L. J. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 3 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1912, to June 3 1914
that I last saw him alive on June 1st 1914
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Nephritis, Chronic

(Duration) 2 yrs mos. ds.
Contributory (Secondary)
(Duration) 1 yrs. mos. ds.

(Signed) L. J. Parker M. D.
6/4- 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	6-14-1914
20. UNDERTAKER	ADDRESS
C. J. Vassar	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8179

Registered No. 29

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nicholas V. Jacobs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH March 28 1914
(Month) (Day) (Year)

7. AGE yrs. 2 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Lewiston

10. NAME OF FATHER N. V. Jacobs

11. BIRTHPLACE OF FATHER (State or Country) Uniontown Wn

12. MAIDEN NAME OF MOTHER Genvre Knapp

13. BIRTHPLACE OF MOTHER (State or Country) Lewiston Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. V. Jacobs
(Address) Lewiston

15.
Filed 7-10- 1914 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 6 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1914, to June 6 1914, that I last saw h[illegible] alive on June 6 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 1 mos. 20 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin S. Bradbury M. D.

June 6 1914 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	June 6 1914

20. UNDERTAKER	ADDRESS
L. Carson	Lewiston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9180
Registered No. 31

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. ....., Bon Aparm St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009

2. FULL NAME Melvin B Colcord

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: June (Month) 10 (Day) 1914 (Year)

7. AGE: 62 yrs. — mos. 19 ds.
IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry business or establishment in which employed (or employer): [illegible]

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Joseph Colcord

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sally Dickenson

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. T. Strouahan M.D.
(Address) Lewiston Ida.

15.
Filed 7-10-1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 28 1914, to June 10 1914, that I last saw h in alive on June 10 1914 and that death occurred on the date stated above, at 9.00 A.M.

The CAUSE OF DEATH* was as follows:
General debility
Pernicious anemia

(Duration) one yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. T. Strouahan M. D.
19..... (Address) Supt Co Hosp

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death? do not know
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: June 12 1914

20. UNDERTAKER: J. Carson — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9C

Primary Registration District No. 1309

County of Nez Perce

City of Lewiston (No. Eagles Club Rooms St.)

File No.

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evan Benbow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 16 1917 (Month) (Day) (Year)

7. AGE: 40 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chief Steam Boat Engineer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: Nathan Benbow

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Larson

(Address) Lewiston

15.

Filed 7-10-1914 R. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at no time 191 , to 191 , that I last saw h alive on no time 191 , and that death occurred on the date stated above, at 11 4 M.

The CAUSE OF DEATH* was as follows:

Peripneutis

Dead when I arrived

(Duration) Some yrs. mos. ds.

Contributory (Secondary)

(Duration) — yrs. mos. ds.

(Signed) J. B. Morris M. D.

19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: June 18 1914

20. UNDERTAKER: C. Glasser. By W. B. Williamson — ADDRESS: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

Registration District No. 9c

Primary Registration District No. 1009

(No. 0115, 8 a St.)

File No. 114

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma E Phelps

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 7 (Day) 1888 (Year)

7. AGE: 25 yrs. 6 mos. 17 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Valley Co Neb

10. NAME OF FATHER: John Dubry

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Nellie Moore

13. BIRTHPLACE OF MOTHER (State or Country): Liverpool Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas E Phelps
(Address) Lewiston Idaho

15.
Filed 7-10-1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1914, to June 23 1914, that I last saw her alive on June 23 1914 and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Nervous Shock. Causing Anuria. (Patient had one K'dney removed about 3 yrs ago.

(Duration) — yrs. — mos. 14 ds.

Contributory (Secondary) Neurosthenia with Chorea Insaniens

(Duration) 5 yrs. mos. ds.

(Signed) Edgar L. White M. D.

June 24 1914 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: June 25 1914

20. UNDERTAKER: C J Vasbor — ADDRESS: Lewiston

By W B Williamson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9L
County of Nez Perce Primary Registration District No. 1009
City of Idaho (No. ..., ... St.)
File No. 9783
Registered No. 84

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fagan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 26 (Month) (Day) 1914 (Year)

7. AGE: ... yrs. ... mos. ... ds. IF LESS than 1 day how many ..... hrs. or ..... min. Four months

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Lewiston Idaho

10. NAME OF FATHER: Ed Fagan

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Flora Fanny

13. BIRTHPLACE OF MOTHER (State or Country): U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Hyatt
(Address) .....

15. Filed 7-10 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 26 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1914, to June 26 1914 that I last saw h alive on June 26 1914 and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:—
Congenital
birth Premature
Four months
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) C W Hyatt M. D.
June 26 1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: June 29 1914

20. UNDERTAKER: C. J. Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8184

Registered No. 95

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hagan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 26 (Month) (Day) 1914 (Year)

7. AGE: few minutes — yrs. ... mos. ... ds. — IF LESS than 1 day how many ..... hrs. or four ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hagan (Fred)

11. BIRTHPLACE OF FATHER (State or Country): W

12. MAIDEN NAME OF MOTHER: Fanny Stone

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Shaff
(Address) .....

15. Filed 7-10-1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 26 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26th 1914., to June 26 1914
that I last saw ~~h~~ alive on June 26 1914
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature birth
Hyaline Lungs dying
a short after birth

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) C W Shaff M. D.
19 ... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho
DATE OF BURIAL: 6-26-1914

20. UNDERTAKER: C. J. Vassar
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9C
Primary Registration District No. 1009
File No. 818
Registered No. 3C

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H. Brunton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 6 (Month) 29 (Day) 14 (Year)

7. AGE: 55 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Josiah Brunton

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Francis Blackburn

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred E Brunston
(Address) Peola Wn

15.
Filed 7-10-1914 L A Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 29th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1914, to June 29th 1914, that I last saw h[illegible] alive on June 28th 1914, and that death occurred on the date stated above, at 12-10 M.

The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
resulting from obstruction of
bowel. Obstruction gave no relief

(Duration) yrs. mos. 5 ds.
Contributory Carcinoma
(Secondary)
(Duration) yrs. mos. 4 ds.
(Signed) F A Kinne M. D.
19 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pomeroy Wn
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Pearson
ADDRESS Pomeroy Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9196
Registered No. 87

1. PLACE OF DEATH. Registration District No. 9L
County of Nez Perce Primary Registration District No. 1009
City of Lewiston, Ida. (No. 2615; Main St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Dennis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: 3 (Month) 23 (Day) 1914 (Year)

7. AGE: ..... yrs. 3 mos. 6 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Orofino, Ida

10. NAME OF FATHER: Reuben Dennis

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Lana Dennis

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. A. Todd
(Address) Lewiston

15. Filed 9-10-1914 Ed Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw her alive on June 29 1914
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Marasmus

(Duration) ..... yrs. 3 mos. ..... ds.
Contributory (Secondary) —
(Duration) ..... yrs. — mos. — ds.
(Signed) E. A. Todd M. D.
6-30 1914 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: June 29 1914

20. UNDERTAKER: C. J. Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8187

Registered No. 38

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

Registration District No. 9
Primary Registration District No. 1609
(No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Pearson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: June (Month) 3 (Day) 1871 (Year)

7. AGE: 43 yrs. 10 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bricky Carpenter
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Moore
(Address) Lewiston Idaho

15.
Filed 7-10- 1914 L J Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1914, to June 3 1914 that I last saw him alive on June 2 1914 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Concussion of brain and other injuries caused by fall from bridge

(Duration) ..... yrs. ..... mos. Two ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Moore M. D.
June 6 1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 6/6 1914

20. UNDERTAKER: Gasser
ADDRESS: Lewiston Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

8188

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau [redacted]
File No. [redacted]
Register [redacted]

1. PLACE OF DEATH.
Registration District No. 4 c
Primary Registration District No. 2 1 3 2
County of Lemhi
City of Gilmore (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. D. W. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: 18 5 2
(Month) (Day) (Year)

7. AGE: 8 2 yrs. ..... mos. ..... da.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Storey
(Address) Gilmore

15. Filed 6/15 191X John Storey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 1 191X
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 191X to June 1 191X that I last saw h. alive on May 31 191X and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia
.....
.....
.....(Duration) ..... yrs. ..... mos. 6 da.
Contributory (Secondary) Cardiac failure
.....(Duration) ..... yrs. ..... mos. ..... da.

(Signed) John Storey M. D.
19 ..... (Address) Gilmore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gilmore
DATE OF BURIAL: June 2 191X

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Coeur d'Alene
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ..... , ... St.)

File No. 8190
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annis Peter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: June 24 (Month) (Day) 1914 (Year)

7. AGE: 66 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Givens
(Address) Orofino, Ida

15. Filed July 1 1914 J. M. Faith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1912, to June 24 1914, that I last saw he alive on June 23 1914, and that death occurred on the date stated above, at 2 p. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Insanity.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John W. Givens M. D.
June 24 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Coeur d'Alene — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Gus Nelson ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8191

Registered No. 30

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

County of Clearwater

City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tomas Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Indian	

6. DATE OF BIRTH: Mar (Month) 15 (Day) 1913 (Year)

7. AGE: 1 yrs. 3 mos. ..... ds. IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Dacota

10. NAME OF FATHER A Harris

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Rose Roy

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Horswell
(Address) Orofino, Ida

15. Filed July 1 1914 J McDaid Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1914, to June 7 1914, that I last saw him alive on June 7 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculer Infection (Miliary)
Broncho Pneumonia
Gastro enteritis
(Duration) yrs. 3 mos. ..... ds.
Contributory (Secondary) Neglect & Improper Hygiene
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. W. Horswell M. D.
July 1 1914 (Address) Oro Fino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Ida	June 8 1914

20. UNDERTAKER	ADDRESS
H. C. Stoddard	Gifford

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ..... St.)

File No. C 13
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Cooney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1847 (Month) 1 (Day) (Year)

7. AGE: 67 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence Hill
(Address) Orofino, Ida

15. Filed July 1 1914 J M Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1914, to June 9 1914, that I last saw him alive on June 8 1914, and that death occurred on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 8 yrs. ..... mos. ..... ds.

Contributory (Secondary): Insanity.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.

June 9 1914 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Orofino, Ida. DATE OF BURIAL: June 11, 1914

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2104
Registered No. 55

1. PLACE OF DEATH.
County of Clearwater
City of Fraser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ..... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Inmay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	

6. DATE OF BIRTH
Mar. (Month) 2 (Day) 1878 (Year)

7. AGE
30 yrs. 6 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Ravenden Springs Ark

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER
(State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER
(State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E B Inman
(Address) Fraser Ida

15.
Filed July 1 1914 J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

?
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory ?
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ✓ M. D.
July 1 1914 (Address) ✓

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fraser Ida
DATE OF BURIAL: June 13 1914

20. UNDERTAKER: W. C. Stoddard
ADDRESS: Gifford

SYMS-YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Dixie
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020
(No. ....., ... St.)

File No. 919
Registered No. 17
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: March (Month) 13 (Day) 1847 (Year)

7. AGE: yrs. 67 yrs. 3 mos. ... da.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Copenhagen

10. NAME OF FATHER: Andrew Anderson

11. BIRTHPLACE OF FATHER (State or Country): Copenhagen

12. MAIDEN NAME OF MOTHER: Marie Sorensen

13. BIRTHPLACE OF MOTHER (State or Country): Copenhagen

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E A Anderson
(Address) Dixie Idaho.

15. Filed June 14th 1914 B W Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 13th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29th 1914, to 1914
that I last saw h im alive on May 29th 1914
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Myocarditis — sudden

(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Enlarged prostate — post-operative asthenia
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) B W Walker M. D.
June 14th 1914 (Address) Mtn. Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho | DATE OF BURIAL: June 14 1914

20. UNDERTAKER: J M Cowen | ADDRESS: Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34

Primary Registration District No. 2020

File No. 9107

County of Ada

City of Meridian (No. ....., ... St.)

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Bandet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	unknown

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 ..... (Year)

7. AGE

27 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER — not Known

11. BIRTHPLACE OF FATHER (State or Country) — " "

12. MAIDEN NAME OF MOTHER — " "

13. BIRTHPLACE OF MOTHER (State or Country) — " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. H. Easton

(Address) Meridian Idaho

15.

Filed June 18th 1914 Burt Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June (Month) 17th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,

that I last saw h— alive on — 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suicide by self inflicted gun shot wounds

..... (Duration) — yrs. ..... mos. ..... ds.

Contributory (Secondary) poor health

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. H. Easton M. D. Coroner

6/17 1914 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? —

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho — DATE OF BURIAL: June 18 1914

20. UNDERTAKER: J. M. Cowen — ADDRESS: Meridian Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M-1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Cold Spring Ranch
City of Cold Spring Ranch (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020

File No. 8197
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Oct (Month) 5 (Day) — 1848 (Year)

7. AGE: 66 yrs. 8 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Joseph Harmon

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: don't know

13. BIRTHPLACE OF MOTHER (State or Country): Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas H Walker
(Address) Glenn's Ferry

15. Filed June 9th 1914 B.O. Mathes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 8 (Day) 1914 (Year) B.W.M

17. I HEREBY CERTIFY, That I attended deceased from June 8 1914, to June 8 1914, that I last saw h[illegible] alive on June 8 1914, and that death occurred on the date stated above, at 3.20 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hamorrhage

(Duration) ..... yrs. ..... mos. 3/4 hours

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W L Draper M. D.
June 9 1914 (Address) Mtn Home Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Idaho | DATE OF BURIAL: June 10 1914

20. UNDERTAKER: J.M. Cowen | ADDRESS: Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

County of Idaho

Primary Registration District No. 2184

City of Kooskia

(No. ....., ... St.)

File No. 2195

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helmi Luoma

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1909 (Year)

7. AGE: 4 yrs. 5 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jacob Luoma

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Ida Raiski

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Luoma

(Address) Kooskia - Idaho

15.

Filed July 1 1914 Jno. Vuberkuus Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1914, to June 14 1914, that I last saw him alive on June 6 1914, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chorea

..... (Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) Endocarditis - Anaemia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. Vuberkuus M. D.

July 15 1914 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Rivita Cemetery Harvey Place

DATE OF BURIAL: June 15 1914

20. UNDERTAKER: None

ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8199

Registered No. 15

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

County of Idaho

City of Kooskia (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Alma Gustin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 24 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 32 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or datablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kooskia - Idaho

10. NAME OF FATHER J. R. Gustin

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Susan Aspaugh

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Vanderkruman
(Address) Kooskia - Idaho

15.
Filed July 1. 1914 J. M. Vanderkruman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1914, to June 28 1914
that I last saw h.a.s.m. alive on June 28 1914
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Malnutrition - Chronic
Enteritis (Indigestion)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Vanderkruman M. D.
June 29 1914 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: June 29 1914

20. UNDERTAKER: None — ADDRESS: —

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

Primary Registration District No. 2049

File No. 8200

Registered No.

County of

City of St Marys

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bert William LaRock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Seventh August Monday 1874
(Month) (Day) (Year)

7. AGE: 40 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Band Musician
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moira Franklin Co Me.

10. NAME OF FATHER: Mitchell LaRock

11. BIRTHPLACE OF FATHER (State or Country): Moira

12. MAIDEN NAME OF MOTHER: Sophia Dunn

13. BIRTHPLACE OF MOTHER (State or Country): Moira

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mitchell LaRock
(Address) Newport Wash.

15. Filed June 29 1914 H. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 28 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1914, to June 28 1914, that I last saw h[illegible] alive on June 28 1914, and that death occurred on the date stated above, at 6[illegible] M.

The CAUSE OF DEATH* was as follows:
Appendicitis

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. E. Cornwall M. D.

6/29 1914 (Address) Athanes Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Newport, Wash. DATE OF BURIAL: 191

20. UNDERTAKER: H. L. Mulcahy ADDRESS: Athanes

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-1

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 8201
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME A C. Rector

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
Dec. (Month) 18 (Day) 1890 (Year)

7. AGE
23 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Workman
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas. Rector

11. BIRTHPLACE OF FATHER (State or Country) Or

12. MAIDEN NAME OF MOTHER Miss. L. Murry

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) St. Maries, Idaho

15. Filed June 27 1914 W. L. Muckley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1914, to June 25 1914, that I last saw h living alive on June 25 1914 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Traumatic shock from loss of both legs in Railroad accident.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. C. Emmanuel M. D.
June 25 1914 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Maries	June 28 1914
20. UNDERTAKER	**ADDRESS**
W. L. Muckley	St Maries

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Falcon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 8202
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rodack Ballas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unknown

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE: About ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Navvy Railroad
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas R Lefurgy
(Address) St Maries

15. Filed January 29 1914 Henry L Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Killed by Great Northern Railroad Accident
Train backing up struck
him on Railroad car

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas R Lefurgy M. D.
19.... (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: January 28 1914

20. UNDERTAKER: H L Mulcahy — ADDRESS: St Maries

SVMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

File No. 8203

County of Latah

City of Plummer

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Emanuel Strandlund Helen Hotel

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 6 (Day) 1876 (Year)

7. AGE: 37 yrs. 9 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wood Cutter
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Reade Co. Myre Sweden

10. NAME OF FATHER: Andrew Peter Strandlund

11. BIRTHPLACE OF FATHER (State or Country): Myre, Co. of Reade. Sweden

12. MAIDEN NAME OF MOTHER: Anna Helena Persson

13. BIRTHPLACE OF MOTHER (State or Country): Tigator Linden Co. Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Helen Strandlund
(Address) Brunswick Minn.

15. Filed June 29 1914 H. L. Medealey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 24 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on June 24 1914.
and that death occurred on the date stated above, at 4½ M. P.m.

The CAUSE OF DEATH* was as follows: Consumption
of Larinks

(Duration) Know yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) Not Known yrs. ..... mos. ..... ds.

(Signed) C. H. Carlisle M. D.

6/28 1914 (Address) Plummer, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? Not Known

Former or usual residence Brunswick, Minn.

19. PLACE OF BURIAL ~~OR REMOVAL~~: Brunswick, Minn. DATE OF BURIAL ..... 191...

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 9204
Registered No.

1. PLACE OF DEATH.
County of Kootnai
City of St. Maries
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ham Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
..... 1
(Month) (Day) (Year)

7. AGE
56 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER
unknown

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER
unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Taylor
(Address) St. Maries

15.
Filed June 29 1914 H. L. Mulcahey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 27 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1914 to June 27 1914
that I last saw him alive on June 27 1914
and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
Comminuted fracture of left femur & dislocation of shoulder. Skull fract.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. V. Boothe M. D.
June 27 1914 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ottumwa, Iowa — DATE OF BURIAL: 1914

20. UNDERTAKER: H. L. Mulcahey — ADDRESS: Stmaries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8205
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elzy White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 25 (Day) 1868 (Year)

7. AGE: 46 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .. Lumberman
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER E. White

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Mary Whitree

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. White
(Address) Walnut, Ill.

15.
Filed June 30 1914 W. E. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1914, to June 29 1914, that I last saw h[illegible] alive on June 28 1914 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Bronchial asthma

..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Cardiac failure.
..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) H. E. Cornwall M. D.
6/29 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Walnut, Iowa
DATE OF BURIAL ..... 191..

20. UNDERTAKER: W. E. Mulcahy
ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 8206
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of St. Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. J. Lemke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 20 (Day) 1 (Year)

7. AGE: 25 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Extra Gang Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: H. M. Lemke

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Miss H. Lemke

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. H. Lemke
(Address) 505 Elmore St. Green Bay Wis.

15.
Filed July 10, 1914 N. Markley Local Registrar

SYMS-YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1914, to July 8 1914
that I last saw h[illegible] alive on July 8 1914
and that death occured on the date stated above, at 9:20 P.M.
The CAUSE OF DEATH* was as follows:
Typhoid fever

(Duration) 1 yrs. ..... mos. 21 ds.
Contributory (Secondary) Erysipelas
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) D. Cornwall M. D.
19..... (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milwaukee Wis — DATE OF BURIAL 1914

20. UNDERTAKER: N. L. Markley — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 92

Primary Registration District No. 2049

File No. 820

County of Kootenai

City of Mar St. Maries (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Don't no

6. DATE OF BIRTH

Don't no (Month) 1 (Day) ..... (Year)

7. AGE about 40 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work Don't no

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) " "

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. P. Bailey Sheriff

(Address) Coeur d Alene Idaho

15.

Filed July 8 1914 H. E. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun shot wound of leg.

Hemorrhage & Shock

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Mulcahy M. D.

19..... (Address) Coroner Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Maries	July 13 1914
20. UNDERTAKER	ADDRESS
H. E. Mulcahy	St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 1049
(No. ..... St.)

File No. 8200
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adelbert J. S Toddard.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 29 (Day) 1870 (Year)

7. AGE: 43 yrs. 11 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: J. M. S Toddard.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Sophia Paige.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Anna S Toddard
(Address) St Maries, Idaho.

15. Filed May 11 1914 W. L. Mudcalay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1913, to May 9 1914, that I last saw h sic alive on May 9 1914 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Carcinoma of pancreas
& liver

(Duration) ..... yrs. 18 mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Cornwall M. D.
19 .... (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries | DATE OF BURIAL: May 11 1914

20. UNDERTAKER: W. L. Mudcalay | ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Joe
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 8216
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Mayfright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
— (Month) — (Day) 1856 (Year)

7. AGE
58 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) W. Virginia

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER —
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Rafter
(Address) Fenell, Idaho

15.
Filed May 13 1914 W. L. Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 12 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1914, to May 12 1914, that I last saw him alive on May 12 1914 and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) 3 yrs. 1 mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Lueta M. D.
May 14 1914 (Address) St Joe Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
St Maries | May 13 1914

20. UNDERTAKER | ADDRESS
W. L. Mulcahy | St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8211
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Blase Comet

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
55 yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: worked in woods
(b) General nature of industry business, or dstablishment in which employed (or employer): Lumberjack

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. H. Platt M. D.
(Address) St Maries

15.
Filed Jany 4 1914 N. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1914, to June 2 1914, that I last saw him alive on June 2 1914 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
General anasarca
which produced heart failure

(Duration) yrs. 3 mos. ds.
Contributory (Secondary) Asthma
(Duration) 1 yrs. mos. ds.

(Signed) Owen D Platt M. D.
6/5 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries | DATE OF BURIAL: June 6 1914

20. UNDERTAKER: N. L. Mulcahy | ADDRESS: St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8212
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of St. Maries
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Petersow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
30 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Pandermaan
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Bulgaria

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D.E. Cornwall
(Address) St Maries

15.
Filed May 13 1914 H.E. Ingleday Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 11 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1914, to May 11 1914
that I last saw h iss alive on May 11 1914
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Rupture of liver
due to injury

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory
(Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D.E. Cornwall M. D.
May 14 1914 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 ... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL
St Maries May 14 1914

20. UNDERTAKER — ADDRESS
H.E. Ingleday St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St. Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 9213
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe Huskey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1864 (Year)

7. AGE: 50 yrs. ~ mos. ~ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Workin in woods
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Joe Huskey
(Address) Santa Ida

15. Filed June 1 1914 H. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1914, to May 31 1914, that I last saw h in alive on May 31 1914 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Tumor of brain

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A L Booker M. D.
19.... (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was *disease contracted* if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: St Maries | DATE OF BURIAL: June 2 1914

20. UNDERTAKER: H L Mulcahy | ADDRESS: St Maries

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St. Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 8215
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. S Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH
..... 1 .....
(Month) (Day) (Year)

7. AGE
62 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Working in woods
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry L. Mulcahy
(Address) St Maries

15.
Filed May 23 1914 H L Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 22 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1914, to May 22 1914
that I last saw h wife alive on May 22 1914
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Oxalic acid poisoning accidental mistook for epsom salts
(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. E. Longwell M. D.
5, 23 1914 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: May 25 1914

20. UNDERTAKER: H L Mulcahy — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8211
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of St Maries (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Viva Velet Plant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Girl		

6. DATE OF BIRTH 20th May Tuesday 1913
(Month) (Day) (Year)

7. AGE yrs. 8 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) None

9. BIRTHPLACE (State or Country) St Maries, Idaho

10. NAME OF FATHER Charles B. Plant

11. BIRTHPLACE OF FATHER (State or Country) Berlin Wisconsin

12. MAIDEN NAME OF MOTHER Marie Teigs

13. BIRTHPLACE OF MOTHER (State or Country) Oconto Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Charles B Plant
(Address) St Maries Idaho

15. Filed Jan 31 1914 H. H. Mulcahey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 31 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1914, to Jan 31 1914, that I last saw her alive on Jan 31 1914 and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows: Intussusception Bowels

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. B. Conwell M. D.

19 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL St Maries, Idaho — DATE OF BURIAL Feb 2 1914

20. UNDERTAKER H. H. Mulcahey — ADDRESS St Maries, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 9221
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Minna Ballard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 28 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: J. N. Prater

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Rodah Nilson

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. N. Prater
(Address) Santa Ida.

15. Filed Feb. 15 1914 H. L. Mackaley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1914, to Feb 14 1914, that I last saw her alive on Feb 14 1914 and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: Paralysis of Heart brought by Septic Edema following miscarriage.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Platt M. D.
Feb 17 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 2/15 1914

20. UNDERTAKER: H. L. Mackaley — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ____, ____ St.)

File No. 8222
Registered No. ____
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elihu Scott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
September 11 (Month) 1857 (Day) (Year)

7. AGE
56 yrs. 3 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer): Hardware

9. BIRTHPLACE (State or Country) Sangamon County Illinois

10. NAME OF FATHER Elihu Scott

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Polly Ann McCoy

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John B Scott
(Address) 634 East Lyon Street Portland Ore.

15.
Filed Jan. 2 1914 W L Imlay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1913, to Jan 1 1914, that I last saw him alive on Jan 1 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ____ yrs. ____ mos. 2 ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) L E Cornwall, M. D.
19 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oakesdale, Wash.	Jan. 3 1914
20. UNDERTAKER	ADDRESS
H. E. Imlay	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8223
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of St Maries Ida. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie E. Cranney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: July (Month) 24th (Day) 1844 (Year)

7. AGE: 69 yrs. 5 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada E. Me

10. NAME OF FATHER: Benj Loonberger

11. BIRTHPLACE OF FATHER (State or Country): Penn-

12. MAIDEN NAME OF MOTHER: Rebecca

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Cranney
(Address) St Maries Idaho

15. Filed Jan 8 1914 J H Brodaday Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1914, to Jan 7 1914, that I last saw h er alive on Jan 5 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D E Cornwall M. D.
1/8 1914 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shifed
DATE OF BURIAL ..... 191...

20. UNDERTAKER: J H Brodaday
ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 32

County of Kootenai

Primary Registration District No. 2049

City of Santa (No. ....., ... St.)

File No. 8224

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah J. Renfro

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 6th (Day) 1848 (Year)

7. AGE: 65 yrs. 2 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Grayson Co Kentucky

10. NAME OF FATHER: Mahewin

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Renfro Family
(Address) Salita Idaho

15. Filed April 20 1914 J. H. Imdeady Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1914, to April 19 1914, that I last saw her alive on April 16 1914 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease
anemia etc.

(Duration) 5 yrs. — mos. — ds.
Contributory (Secondary) Rheumatism, Kidney disease
(Duration) 5 or 6 yrs. — mos. — ds.

(Signed) C. J. Kincaid M. D.
April 22 1914 (Address) St Maries Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 24 yrs. ..... mos. ..... days. In the State 30 yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence: Santa Idaho

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: April 22 1914

20. UNDERTAKER: J. H. Imdeady — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 32
County of Kootenai
Primary Registration District No. 2049
File No. 8225
City of Athol (No. ....., ... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME T. O. Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 23 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Mining
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ark.

10. NAME OF FATHER J. A. Patterson

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Miss Crockett

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Patterson
(Address) Kellogg, Idaho.

15. Filed March 6 1914 H. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar 5th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25th 1914, to Mar 5th 1914, that I last saw h-em alive on Mar 5th 1914 and that death occurred on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
General Peritonitis
.....
.....
..... (Duration) ..... yrs. ..... mos. 9 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Owen D Hall M. D.
Mar 6 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Coeur d'Alene	..... 191...

20. UNDERTAKER	ADDRESS
H. L. Mulcahy	Athol

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ..., ... St.)

File No. 224
Registered No. ...
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Jacobson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
3rd March 1891
(Month) (Day) (Year)

7. AGE
23 yrs. ... mos. 28 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Car Repairer
(b) General nature of industry business, or dstablishment in which employed (or employer) Railroad

9. BIRTHPLACE (State or Country) Lansing Minnesota

10. NAME OF FATHER Jacob Jacobson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Laura Jenson

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edw L Jacobson
(Address) Plummer Ida

15. Filed April 2 1914 H L Inskeep Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 31 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 31 1914, to Mch 31 1914, that I last saw h alive on Mch 31 1914 and that death occurred on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:
Crushing injuries left arm, left leg, right leg
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) Traumatic Shock
(Duration) ... yrs. ... mos. 4 hrs ds.
(Signed) L L Cornwall M. D.
3/31 1914 (Address) L L Cornwall

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Plummer Idaho — DATE OF BURIAL ... 191...

20. UNDERTAKER H L Inskeep — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 822
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Max Schmoldt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Don't no.

6. DATE OF BIRTH
Don't no (Month) 1 (Day) (Year)

7. AGE About 38 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Don't no Pukaffs
(b) General nature of industry business, or dstablishment in which employed (or employer) Lumber Jack

9. BIRTHPLACE (State or Country) Don't no

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H L Mulcahy
(Address) St Maries

15. Filed March 14 1914 H L Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8th 1914, to Mar 13th 1914
that I last saw him alive on Mar 13th 1914
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Uraemic poisoning due to suppressed urine

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. mos. 10 ds.

(Signed) Owen D Hall M. D.
Mar 23 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: March 23 1914

20. UNDERTAKER: H L Mulcahy — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8225
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of St Maries (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lambert Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 5 (Day) 1913 (Year)

7. AGE: 1 yrs. 6 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spokane

10. NAME OF FATHER: W Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary A Boyle

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Sullivan
(Address) 1114 E. Nora Ave. Spokane, Wash.

15. Filed March 15 1914 O. L. Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1914, to March 15 1914, that I last saw him alive on 11 1914 and that death occurred on the date stated above, at 7.15 P.M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Owen D Pond M. D.
Mar 23 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries, Idaho — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: H. E. Muckaley — ADDRESS: St Maries Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 8231
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elda M. Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 5 (Day) 1879 (Year)

7. AGE: 37 yrs. ... mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salem Ore

10. NAME OF FATHER: Lafayette Williams

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Miss Rogers

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. N. Williams
(Address): Mount Sun, Idaho.

15. Filed March 23 1914 H. L. Mudgley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March. (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Mar 22 1914, that I last saw her alive on Mar 22 1914 and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) 2 yrs. ... mos. ... ds.

(Signed) Owen D. Platt M. D.
Mar 24 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE ~~OF BURIAL OR~~ REMOVAL: Lewiston Ida | DATE OF BURIAL: March 25 1914

20. UNDERTAKER: H L Mudgley | ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St. Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 8232
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John M. Fredrickson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: 56 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Worked in Woods.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. H. Cornwall
(Address) St. Maries

15.
Filed March 25 1914 W. E. Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1914, to March 23 1914, that I last saw h... alive on March 23 1914, and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:
Organic heart disease and nephritis.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Cornwall M. D.
19 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: St Maries | DATE OF BURIAL: March 26 1914

20. UNDERTAKER: W. E. Mulcahy | ADDRESS: St Maries

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8233
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of Fernell (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. J. Hubble
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
March 1 (Month) (Day) 1 (Year)

7. AGE about 47 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Le Roy Hubbell
(Address) St. Joe, Idaho

15. Filed April 4 1914 W. E. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1914, to April 3 1914 that I last saw him alive on April 3 1914 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) — yrs. — mos. — ds.
Contributory (Secondary) Rheumatism of the Heart
(Duration) yrs. mos. 1/2 hours ds.

(Signed) H. M. Leete M. D.
4/4 1914 (Address) St Joe Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Coeur d'Alene | DATE OF BURIAL 191...

20. UNDERTAKER W. E. Mulcahy | ADDRESS St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Burke
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 2200
(No. ..., ... St.)

File No. 8234
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Child Berry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH
June (Month) 11 (Day) 1914 (Year)

7. AGE
... yrs. ... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Burke,

10. NAME OF FATHER J. R. Berry

11. BIRTHPLACE OF FATHER (State or Country) Ino.

12. MAIDEN NAME OF MOTHER Gertie Baisley

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Berry
(Address) Burke, Ida

15.
Filed 6/20 1914 H. S. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1914, to June 12 1914, that I last saw h... alive on June 11 1914, and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:
Immaturity at birth

(Duration) ... yrs. ... mos. 1 ds.
Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.
(Signed) C. O. Bunce M. D.
June 19 14 (Address) Burke

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace
DATE OF BURIAL: June 12th 1914

20. UNDERTAKER: Wards Undertaking Co
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2207
File No. 8235
Registered No. 11

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. About one mile east of Wallace)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Theodore Von Moltke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 18 (Day) x1834 (Year)

7. AGE: 79 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Geo von Moltke
(Address) Wallace Idaho

15. Filed 6/12 1914 H. E. Mowry Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1914, to June 6 1914, that I last saw him alive on June 5 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Paralysis of Bowels
2

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Age & general debility
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. A. Downs M. D.
1914 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 20 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: June 10 1914

20. UNDERTAKER: Bruce & Masters
ADDRESS: Wallace Id

FORM V [illegible] M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2200
File No. 8236
Registered No. 10

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin St Jean

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
60 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Conv. salesman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) England

10. NAME OF FATHER
Jas. St Jean

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER
[illegible]

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. J. St Jean
(Address) Mullan Idaho

15.
Filed 6/10 1914
[illegible] Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease
(Duration) 10 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) D. K. Mowry M. D.
June 19 14 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Ward. Undertaking — ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2138
(No. [illegible])

File No. 923
Registered No. 48
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Emerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Don't know

6. DATE OF BIRTH: Do not know
(Month) (Day) (Year)

7. AGE: about 35 Years
yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Reyonng
(Address) Rexburg

15. Filed July 1 191X
G T Cook
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 29 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1914, to June 29 1914, that I last saw him alive on June 29 1914 and that death occurred on the date stated above, at 4.0 M.

The CAUSE OF DEATH* was as follows:
Suicide by discharge of some explosive in mouth: lives about 10 hrs. after explosion
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) F M Emerson M. D.
June 30 1914 (Address) Rexburg, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg. DATE OF BURIAL: 7/1 1914

20. UNDERTAKER: J Reyonng ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 1760

This Information I have Got from his Letter to his Parents

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 102
Primary Registration District No. 2178
(No. ..... , ... St.)

File No. 8238
Registered No. 47
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse P. Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 16 (Day) 1839 (Year)

7. AGE: 74 yrs. 4 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Jacob C Peterson

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Christina E. Miller

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Peterson
(Address) R.F.D. 1 — City Rexburg

15. Filed July 1 1914 — G. L. Espe, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 29th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1st 1914, to June 29th 1914, that I last saw her alive on June 28th 1914, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
General breaking down
from old age

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. O. Osmus M. D.
6/30 1914 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burton	6/30 1914

20. UNDERTAKER	ADDRESS
W Cooney	Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No. 2424
File No. 8241
Registered No. 1

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin Andrew Younger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Single

6. DATE OF BIRTH
1 (Month) 5 (Day) 1914 (Year)

7. AGE
yrs. 5 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work #1
(b) General nature of industry business, or dstablishment in which employed (or employer) #1

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Maurice Younger

11. BIRTHPLACE OF FATHER (State or Country) Ver.

12. MAIDEN NAME OF MOTHER Vivian Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. C. Jeffreys
(Address) Nezperce Ida

15.
Filed 7-10 1914 W. M. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
7 (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-29-1914, to 7-4-1914, that I last saw him alive on 7-4-1914, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Ulcerative Endocarditis
.....
.....
.....(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Foliculer Tonsilitis
.....(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) O. C. Jeffreys M. D.
July 6 1914 (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Nezperce Ida | DATE OF BURIAL 7-6-1914

20. UNDERTAKER P. E. Miller | ADDRESS Nezperce Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8242
Registered No. 8

1. PLACE OF DEATH.
County of Lemhi
City of Nr Salmon

Registration District No. 47
Primary Registration District No. 2174
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Belle Swartz

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: May (Month) 9 (Day) 1867 (Year)

7. AGE: 47 yrs. 1 mos. 17 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hus.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Joseph Cowley

11. BIRTHPLACE OF FATHER (State or Country): U S

12. MAIDEN NAME OF MOTHER: Cowley

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W L Swartz
(Address) Nr Salmon Ida

15.
Filed 7-10 1914 J M Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1914, to June 24 1914
that I last saw her alive on June 24 1914
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Pernicious Anaemia

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. G. Jeffreys M. D.
1914 (Address) Nr Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nr Salmon
DATE OF BURIAL: June 28 1914

20. UNDERTAKER: P. E. Miller
ADDRESS: Nr Salmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Hailey
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 8244
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hos-Wm Barrington?

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower.

6. DATE OF BIRTH: August 27. (Month) (Day) 1866. (Year)

7. AGE: 47 yrs. 9 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laurece Barrington
(Address) Hailey Idaho

15. Filed June 25 1914 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 23 1914
that I last saw h[illegible] alive on June 23 1914
and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

(Duration) 5 yrs. mos. ds.

Contributory (Secondary)
(Duration) 4 yrs. mos. ds.

(Signed) Robert H Wright M. D.
June 29 14 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida — DATE OF BURIAL: June 25 1914

20. UNDERTAKER: R. L. Harris — ADDRESS: Hailey Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 245
Registered No. 11

1. PLACE OF DEATH.
County of Blaine
City of Hailey
(No. ..... , Morreaus St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Maureau

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: French.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: — — 1 — (Month) (Day) (Year)

7. AGE: 67 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Herder
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. C. Montgomery
(Address) Hailey

15. Filed June 12 1914 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1914, to June 10 1914, that I last saw h[im] alive on June 10 1914 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows: (Tick)
Rocky Mountain Spotted Fever
(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Senility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
19 ..... (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: California | DATE OF BURIAL: Unknown 191

20. UNDERTAKER: D. D. Harris | ADDRESS: Hailey Ida

SYMS - YORK CO. PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8246

Registered No. 10

1. PLACE OF DEATH.

Registration District No. 21

Primary Registration District No. 2022

County of Blaine.

City of Hailey. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Frances Horne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH: September. 23 1857.
(Month) (Day) (Year)

7. AGE: 56 yrs. 8 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife,
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa,

10. NAME OF FATHER: Presley Higgins.

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Sidnaplee Walker

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. J. Horne
(Address) Hailey, Idaho

15. Filed June 5 1914 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 2 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1914, to June 2 1914, that I last saw her alive on June 2 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. mos. 6 ds.

(Signed) John J. Raaf M. D.

June 3 1914. (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ralph S Harris — DATE OF BURIAL: June 3 1914

20. UNDERTAKER: Hailey Ida — ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 81
County of Bonner Primary Registration District No. 2158
City of Priest River (No. ....., ... St.)
File No. 8245
Registered No. 7
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Frederick Augustus Dodge,
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: January (Month) 17th (Day) 1843 (Year)

7. AGE: 71 yrs. 5 mos. ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): (Late Pvt.1st Wis. Heavy Art.Co.H)

9. BIRTHPLACE (State or Country): Seneca Falls, N.Y.

10. NAME OF FATHER: Lyman Dodge

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Emily Howe

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ida E. Dodge, (Wife)
(Address) Priest River, Idaho.

15.
Filed June 30 1914 Edmeeahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 3rd 1913, to June 27th 1914 that I last saw him alive on June 27th, 1914, and that death occurred on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:
Bulbar Paralysis
(Gloss-Labio-Laryngeal-Paralysis)
(Duration) yrs. 7 mos. 28 ds.
Contributory (Secondary) A previous paralysis
(Duration) 3 yrs. mos. ds.
(Signed) Fredk W. Didier M. D.
June 30 1914 (Address) Priest River, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs... ..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Priest River Ida
DATE OF BURIAL: July 1st 1914

20. ~~UNDERTAKER~~
ADDRESS
Richard M. Meade Priest River Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Greencreek
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2103
(No. ....., ... St.)

File No. 10 8249
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Casper Hunzel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1838 (Year)

7. AGE: 76 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common laborer.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Barney Westhoff
(Address) Green Creek Ida

15.
Filed June 7 1914 H Bosche
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ ~~the~~ June 6 1914; ~~to~~ ~~191~~
~~that I last saw h~~ ~~alive on~~ ~~191~~,
and that death occurred on the date stated above, at Not known M.

The CAUSE OF DEATH* was as follows:
(Natural) Causes unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Senile debility
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Steinnick M. D.
June 7 1914 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green Creek Idaho — DATE OF BURIAL: June 8 1914

20. UNDERTAKER: Harry M West — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Clearwater (No. ____, St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183

File No. 11 825

Registered No. ____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charlie F Miller.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January (Month) 29 (Day) 1881 (Year)

7. AGE: 33 yrs. 4 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): ---

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Lee Miller

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Anna S Franswick

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William J Miller
(Address) Winona Idaho

15.
Filed June 11 1914 H Bolke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated the death of deceased ~~from~~ ~~191~~ ~~to~~ ~~191~~ ~~that I last saw him alive~~ on June 11th 1914, and that death occurred on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:
Suicide by Firearms

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Alcoholism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Bolke Coroner M. D.
June 11 1914 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lenore Idaho — DATE OF BURIAL: June 12 1914

20. UNDERTAKER: Tenyon West — ADDRESS: Cottonwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

WMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9825
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Kentonville Precinct
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edmond Fitzgerald

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 24 (Day) 1832 (Year)

7. AGE: 82 yrs. — mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Nicholas Fitzgerald

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Butler

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Forsmann
(Address) Cottonwood Ida

15.
Filed June 21 1914 H W Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated the death of deceased ~~191~~ ..., 191..., to ..., ~~191~~ ... and that ~~I last saw him alive on~~ ~~191~~ ... and that death occurred on the date stated above, at 3³⁰ P. M.

The CAUSE OF DEATH* was as follows:

Causes Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile debility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Blake M. D.
June 21 1914 (Address) Coroner Kentonville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida
DATE OF BURIAL: June 23 1914

20. UNDERTAKER: Farr & West
ADDRESS: Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 105
County of Idaho Primary Registration District No. 2183 File No. 13 8252
City of Green Creek (No. ....., ... St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Elizabeth Westhoff
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH: December (Month) 25 (Day) 1842 (Year)
7. AGE: 72 yrs. 7 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Hundel
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Barney Westhoff
(Address) Green Creek Ida
15.
Filed June 26 1914 H Boen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 21 1914, to June 24 1914 that I last saw her alive on June 24 1914, and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:
Valvular disease of Heart
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Lobar Pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. D. Steinnick M. D.
June 25 1914 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green Creek. DATE OF BURIAL: June 27 1914
20. UNDERTAKER: Harry D. Kyle ADDRESS: Cottonwood Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Jefferson

City of Garfield

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 2176

(No. ....., ... St.)

File No. 825

Registered No. 20

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest Severson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH

July (Month) 2 (Day) 1914 (Year)

7. AGE

..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..2.. hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Oscar Severson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Agnes Rasmussen

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar Severson

(Address) Rigby, Ida. R.F.D

15.

Filed July 10 1914 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.., to ..... 191..., that I last saw him alive on from July 2 1914 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Premature heart - lack of vitality.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Paxton M. D.

July 2 1914 (Address) Rigby, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grant	July 3 1914
20. UNDERTAKER	ADDRESS
Friends	Rigby R.F.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

File No. 132 0254

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. Fasner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) 1 (Day) 1849 (Year)

7. AGE: 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Jordan Valley, Ore.

15.

Filed May 31st, 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14 1914, to May 30 1914, that I last saw h. alive on May 30 1914, and that death occured on the date stated above, at 2. A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma (Cancer) of Pancreas

(Duration) ..... Yrs. 8 mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. R. McCabe M. D.

5/31 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 3 mos. ..... days In the State ..... yrs. 8 mos. ..... days

Where was disease contracted if not at place of death? Jordan Valley Oregon

Former or usual residence Jordan Valley, Oregon

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	5/31 1914
20. UNDERTAKER	**ADDRESS**
Schreiber & Siddenfaden	Boise Idaho

M. B. Cahill

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8251

Registered No. 133

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1904

County of Ada

City of Boise (No. Cor 2 and Leadville St.)

South Side

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Lake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May (Month) 4 (Day) 1843 (Year)

7. AGE: 71 Yrs. — Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): La.

10. NAME OF FATHER: Henry Lake

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unbekannt

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H A Lake

(Address) 701 Main Boise

15. Filed 6-1 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1913, to May 30 1914, that I last saw h[illegible] alive on May 28 1914, and that death occured on the date stated above, at 7.30 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) M D.

6/1 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF ~~BURIAL~~ Burial: 6/1 1914

20. UNDERTAKER: Schreiber & Anderson

ADDRESS: Boise

Talmon.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 134 825

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. South Dorie Street)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothee Elizabeth Malbus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. June (Month) 13 (Day) 1834 (Year)

7. AGE: 80 Yrs. 11 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Johannes Stolz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Carolina Hasenflug

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Michel

(Address) Boise Idaho

15.

Filed June 1st, 1914

M. B. Ahern
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1912, to May 1914, that I last saw her alive on May 21 1914, and that death occured on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Senile

(Duration) 2 Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Hall M. D.

6/1 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: Jun 2 1914

20. UNDERTAKER: Schreiber & Sidlo — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGR. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8259
Registered No. 135

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 920 Brumback St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur J. Menter.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July 20 1869 (Month) (Day) (Year)

7. AGE: 44 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Deputy Sheriff
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Greenbay, Wis

10. NAME OF FATHER John Menter

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Ann Telpaugh

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs A J Menter
(Address) Boise, Idaho.

15. Filed 6-7 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 31 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1914, to May 31 1914, that I last saw him alive on May 30 1914, and that death occured on the date stated above, at 9:40 a M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis affecting auricular ventricular muscle-bundle
(Duration) 4 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) M. D. Dallenbaugh M. D.
6/1 1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/3 1914

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 423 Bessigner St.)

File No. 137 8266

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Delia Farrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 29th (Day) 1839 (Year)

7. AGE: 75 Yrs. — Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER James O'Brien

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Mrs Mary McGough

15. Filed June 4th, 1914 — Boise — M S Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to June 2 1914, that I last saw h[illegible] alive on June 1914, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation or leak. (Heart disease)

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) L. D. McCall M. D.

6/4 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: June 5 1914

20. UNDERTAKER: Schreiber & Hickenfoden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8261

Registered No. 138

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St. Alphonsus Hosp St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Huggs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 5 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... Ds.

IF LESS than 1 day how many ..... hrs. or 20 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER Nelson B Huggs

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Josephine Faull

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nelson B Huggs

(Address) Horseshoe Bend, Idaho

15.

Filed 6-6 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1914, to June 5th 1914, that I last saw her alive on June 5th 1914, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Malformation of Pylorus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Lee Burke M. D.

19.... (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Horse Shoe Bend, Idaho	June 7 1914
20. UNDERTAKER	**ADDRESS**
Fry & Summers	Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

8VM8 - YORK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 7

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 262

Registered No. 139

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 220 W Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roxanne Elizth Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar (Month) 28 (Day) 1914 (Year)

7. AGE: ....Yrs. 2 Mos. ....ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Edwin G Davis

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Elsie Poll

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E M Davis

(Address) Boise, Idaho

15. Filed 6-9 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1914, to June 8 1914, that I last saw h[illegible] alive on June 8 1914 and that death occured on the date stated above, at 12-15 M.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(Duration) ....Yrs. ....mos. 2 ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) O Hurley, M. D.

June 8 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetary — DATE OF BURIAL: June 10 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
File No. 7826
Registered No. 140

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 1316 N 7 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles B. Tyson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	married

6. DATE OF BIRTH. Mar (Month) 27 (Day) 1844 (Year)

7. AGE 70 Yrs. 2 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rena Lyon
(Address) 1316 No. 7th St.

15. Filed 6-10 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased from ..... 191..., to ..... 191..., ~~that I last saw h alive on ..... 191...~~ and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Uraemia, Cystitis
Ureterolithiasis
Pyelitis
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ada Yale Schrunk M.D.
19.... (Address) Boise Ada Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — DATE OF BURIAL June 10 1914

20. UNDERTAKER Fry & Summers — ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 8264

County of Ada

City of Boise (No. 416 Jefferson St.)

Registered No. 142

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Elizabeth Corker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. November 21 1829 (Month) (Day) (Year)

7. AGE: 84 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Marcus Bantus Gibson

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Annie Grant

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frances Corker Nourse
(Address) Boise

15. Filed 6-12 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11th 1914, to June 11 1914, that I last saw her alive on June 1, 1914 and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) General Debility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J S Springer M. D.

June 19 14 (Address) Boise Ada

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home — DATE OF BURIAL: May 13 1914

20. UNDERTAKER: Schreiber & Siebenfoden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8265
Registered No. 143

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie H. Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. Dec 16 (Month) (Day) 1869 (Year)
7. AGE: 44 Yrs. 5 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): -
9. BIRTHPLACE (State or Country): Ada Co. Idaho.
10. NAME OF FATHER: A. H. Wylie
11. BIRTHPLACE OF FATHER (State or Country): Muskingum Co, Ohio
12. MAIDEN NAME OF MOTHER: Mary Perkins
13. BIRTHPLACE OF MOTHER (State or Country): Iowa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Jones Samatrum
(Address): R#2 Boise
15. Filed 6-13 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 12 1914, that I last saw h-er alive on June 12 1914, and that death occured on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
Post anesthetic
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edmond Jones M. D.
19.... (Address) 208 Idaho Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 2 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/14 1914
20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 8266

Registered No. 745

1. PLACE OF DEATH.

County of Ada.

City of Boise

(No. St Alphonsus Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Carr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 16 (Day) 1914 (Year)

7. AGE ....Yrs. ....Mos. ....ds.

IF LESS than 1 day how many. 3 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Boise Idaho.

10. NAME OF FATHER Sidney Carr.

11. BIRTHPLACE OF FATHER (State or Country) Colorado.

12. MAIDEN NAME OF MOTHER Ora Schiller

13. BIRTHPLACE OF MOTHER (State or Country) Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. L. Williamson M. D.

(Address) 824 Franklin St.

15. Filed 6-16 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw him alive on 16 June 1914, and that death occured on the date stated above, at 10 3/4 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) R. L. Williamson M. D.

19.... (Address) 824 Franklin

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	June 17 1914
20. UNDERTAKER	ADDRESS
Frey & Summers.	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8268

Registered No. 147

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 110 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Warburton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Not obtainable (Month) (Day) 1 (Year)

7. AGE: About 70 Years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adolph Schreiber

(Address) Boise

15.

Filed 6-17 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 17 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 14 1914

that I last saw h— alive on June 14 1914

and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Cerebrosis

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) J. E. Stucky M. D.

19.... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill County Plot — DATE OF BURIAL: 6/19 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8269

Registered No. 148

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 814 Jukes Roof St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David V. Goss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Jan. (Day) 5 (Year) 1876

7. AGE: 38 Yrs. 5 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER A. K. Goss

11. BIRTHPLACE OF FATHER (State or Country) N. Carolina

12. MAIDEN NAME OF MOTHER Sarah Henry

13. BIRTHPLACE OF MOTHER (State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. D. V. Goss

(Address) Parma, Idaho

15. Filed 6-17 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1914, to June 17 1914, that I last saw h[illegible] alive on June 14 1914, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) Y[illegible] mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. A. Springer M. D.

June 14 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma Ida — DATE OF BURIAL: June 18 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BVM6 - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2[illegible]

Registered No. 14[illegible]

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 506 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonhart Harle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 1st (Day) 1906 (Year)

7. AGE: 8 Yrs. 2 Mos. 17 ds.

IF LESS than 1 day how many ... hrs. ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none, Student

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minneapolis, Minn.

10. NAME OF FATHER: Meinrad Harle

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Cunegunda Frayer

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Meinrad Harle

(Address)

15. Filed 6-18 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June [redacted] 1914, to June 18th 1914, that I last saw him alive on June 17th 1914, and death occured on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH* was as follows:

Lipothymia

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) Hayes Baer M. D.

19 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence 506 Idaho St Boise Ida

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/18 1914

20. UNDERTAKER: Schreiber & Bideyfader — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 271

Registered No. 170

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 110 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Phillipps

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dont Know (Month) (Day) 1 (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R E Shurtz
(Address) .....

15. Filed 6-19 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 17. (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 17 1914, that I last saw h... alive on 17th June 1914, and that death occured on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Hepatic Abcess

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E Shurtz M. D.

19.... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill County Plot — DATE OF BURIAL: 6/20 1914

20. UNDERTAKER: Silverbin Children[illegible] — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2272

Registered No. 152

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 112 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Louisa Givens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 2 (Day) 1860 (Year)

7. AGE: 54 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: T. W. Melick

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Louisa Sellers

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) J. F. Melick Nampa Ida

15. Filed 6-20 1914 W. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1914, to June 19 1914, that I last saw h[illegible] alive on June 19 1914, and that death occured on the date stated above, at 12 Mid. M.

The CAUSE OF DEATH* was as follows:

Infected Fibroid Tumor of Ovary

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Smith M. D.

6/20 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Nampa Idaho.

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: 6/21 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [redacted]

Registered No. 153

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack Leroy Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 14 (Day) 1910 (Year)

7. AGE: 4 Yrs. 4 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mountain Home Idaho

10. NAME OF FATHER: Albert Evans

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Mary F. Daniels

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W L Evans

(Address) Inter Home Ada

15. Filed 6-22 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/21 1914, to 6/22 1914, that I last saw him alive on 6/22 1914, and that death occured on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:

Accidental Kicked in head & skull fractured

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A Ritzman M. D.

6/22 1914 (Address) Lake Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. 1 days

Where was disease contracted if not at place of death? Mt Home

Former or usual residence Mt Home

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida. DATE OF BURIAL: 6/22 1914

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8274
Registered No. 154

1. PLACE OF DEATH.

County of Ada
City of Boise (No. 410 Alta St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry McDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 6 (Day) 1869 (Year)

7. AGE: 44 Yrs. 9 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Contractor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bristol Ind

10. NAME OF FATHER Albert McDonald

11. BIRTHPLACE OF FATHER (State or Country) Bristol Idaho

12. MAIDEN NAME OF MOTHER Eurusa Fields

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Carl
(Address) Nampa Ida

15.
Filed 6-22 1914. M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1914, to June 20 1914, that I last saw him alive on June 20 1914, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Abscess of lungs

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. L. Titus M. D.
June 22 1914. (Address) 315 Overland

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/22 1914

20. UNDERTAKER: Schreiber & Hidenfadern — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 5-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8275
Registered No. 155

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1620 N 13 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George C Lorimer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 2 (Day) 1832 (Year)

7. AGE: 82 Yrs. 4 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brick mason
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: G C Lorimer

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas F. Lorimer
(Address) 1304 N. 13th

15. Filed 6-22 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1914, to June 22 1914, that I last saw h[illegible] alive on June 12 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Uraemia. Chronic Brights disease. Was incapacitated past 2 1/2 or 3 years
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Enlarged prostate.
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) L. P. McCall M. D.
19..... (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 22 1914

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 827

Registered No. 157

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 2

County of Canyon Primary Registration District No. 1004

City Star Falls Star (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Lyman Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 26 (Day) 1903 (Year)

7. AGE: 10 yrs. 11 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Student
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Edward L. Miller

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Cora Shipman

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) New Plymouth R.D. # 2

15.

Filed 6-24 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..... 191 , to ..... 191 ..... that ~~I last saw h~~ ..... alive on ..... 191 , and ~~that~~ death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

accidental Drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred K. Robinson Correct M. D.

6/25 1914 Address Boise Ida Canyon Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, If not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery Boise Ida

DATE OF BURIAL: 6/26 1914

20. UNDERTAKER: Scrieber & Siefenfaden

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
File No. 8278
Registered No. 158

1. PLACE OF DEATH.
County of Ada
City of Boise, (No. 1814 Lemp St St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Horace C Waynire

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug 22 1834 (Month) (Day) (Year)

7. AGE: 79 Yrs. 10 Mos. 4 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio, Mentar

10. NAME OF FATHER David Waynire

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER M. Collins

13. BIRTHPLACE OF MOTHER (State or Country) Mass,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H A Waynire
(Address) Boise Idaho

15.
Filed 6-27 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 27th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....1914....., to .....1914.....,
that I last saw h.....alive on .....1914.....,
and that death occured on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Myocarditis.
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) Hemiplegia
.....(Duration) .....Yrs.....mos.....ds.
(Signed) W A Taylor M. D.
June 27 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence 1914 Lemp St (Boise)

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/29 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 9274
Registered No. 159

1. PLACE OF DEATH.
County of Ada
City of near Eagle (No. near Eagle Station St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Jullion

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. May (Month) 2nd (Day) 1836 (Year)
7. AGE: 78 Yrs. 1 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Ire-Le-Sec France
10. NAME OF FATHER Jos. Jullion.
11. BIRTHPLACE OF FATHER (State or Country) France
12. MAIDEN NAME OF MOTHER Not Ataniable
13. BIRTHPLACE OF MOTHER (State or Country) France
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Jullion
(Address) Boise, Ida
15. Filed 6-27 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 25th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ died ~~19..~~, to ~~19..~~, that I last saw him alive on June 25th 1914, and that death occured on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Adolph Schreiber M. D. Coroner
19.... (Address) Ada Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/28 1914
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 1004

File No. 4241

Registered No. 161

1. PLACE OF DEATH.

County of Ada.

City of Boise (No. 1512 No 12. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Stalker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S.

6. DATE OF BIRTH. June 28 1914 (Month) (Day) (Year)

7. AGE ____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ... hrs. or ... min.? 3 hrs.

8. OCCUPATION

(a) Trade, profession or particular kind of work: ____

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country) Boise Idaho.

10. NAME OF FATHER Henry A. Stalker

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Stella Morehouse.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry A. Stalker

(Address) 1515 No 12th

15. Filed 6-29 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1914, to June 28 1914, that I last saw her alive on June 28 1914, and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Non closure of foramen ovale — Malformation

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ____

(Duration ... yrs. ... mos. ... ds.

(Signed) John Brueck M. D.

(Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: June 29 1914

20. UNDERTAKER: Fry & Summers. ADDRESS: Boise Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RDRS. 24858

FORM V. S. No. s-25 R 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 2281
Registered No. 162

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 613 Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sanford V. Fuller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Feb. (Month) 13 (Day) 1854 (Year)

7. AGE: 55 Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Sanford Fuller

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Martha Jane Spafford

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hannah Chase
(Address) Rigby

15. Filed 6-29 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ dead 191 ~~to~~ 191, that I last saw h~~alive on~~ June 25 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Uremia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Adolph Schreiber M.D.
19..... (Address) Boise Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/30 1914

20. UNDERTAKER: Schreiber & Siebenfeder — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

(No. 412 State St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8282

Registered No. 163

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Ashley Jellison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 2d (Day) 1872 (Year)

7. AGE 42 Yrs. 2 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Monument Dealer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Santiago, Maine

10. NAME OF FATHER Edwin A Jellison

11. BIRTHPLACE OF FATHER (State or Country) Ills.

12. MAIDEN NAME OF MOTHER Nancy Sanders

13. BIRTHPLACE OF MOTHER (State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E J Jellison

(Address) Boise.

15.

Filed 6-29 1914

M S Parker
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 27th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1914, to June 27 1914, that I last saw h[illegible] alive on at June 27 1914, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Alcoholism

.....(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Halverson M. D.

June 29 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — DATE OF BURIAL 6/30 1914

20. UNDERTAKER Schreiber & Sidenfaden — ADDRESS Boise Ida.

Dr. Halverson.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004

(No. 406 So 4th St.)

File No. 8283

Registered No. 167

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rose Richards Paine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan. (Month) 14 (Day) 1834 (Year)

7. AGE: 80 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Coster Richards

11. BIRTHPLACE OF FATHER (State or Country): New York ~~Mass~~.

12. MAIDEN NAME OF MOTHER: Green

13. BIRTHPLACE OF MOTHER (State or Country): New York. ~~Mass~~.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Karl Paine

(Address) 406 South 4th St.

15. Filed 6—30 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1913 to June 28 1914, that I last saw her alive on June 28 1914, and that death occured on the date stated above, at 12:35 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of right breast

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. E. Blevans M. D.

6/29 1914 (Address) In Carly Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/30 1914

20. UNDERTAKER: Schreiber & Eidenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
(No. Perkins Station St.)

File No. 8284
Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of near Perkins
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Giese

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Nov 11 (Month) (Day) 1834 (Year)

7. AGE: 79 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Richard R. Giese
(Address)

15. Filed 6-15 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 14th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1914, to June 14 1914, that I last saw her alive on June 14th 1914, and that death occured on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary): Senility
(Duration 2 yrs. mos. ds.
(Signed) John Buck M. D.
June 15 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/15 1914

20. UNDERTAKER: Schreiber & Hidenfader — ADDRESS: Boise

Dr. Buck.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 8285
Registered No. 27

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. near Ustick Station St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Brickerhoff H. Ratekin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 26th (Day) 1867 (Year)

7. AGE: 46 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): at Manville Fruit Co.

9. BIRTHPLACE (State or Country): Bates Co. Mo.

10. NAME OF FATHER: Jas. M. Ratekin

11. BIRTHPLACE OF FATHER (State or Country): Galloway Co Mo

12. MAIDEN NAME OF MOTHER: Elizth Burcha

13. BIRTHPLACE OF MOTHER (State or Country): Bates Co. Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Mrs B. H Ratekin Boise Ida.

15. Filed 6-4 1914
M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30th 1914, to May 30th 1914, that I last saw him alive on May 2nd 1914, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jos. Bacon M. D.
June 2 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill cemetery
DATE OF BURIAL: 6/4 1914

20. UNDERTAKER: Schreiber & Sidinfaden
ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & SORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 11

Primary Registration District No. 2003

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8286

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Meridian Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Robison

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 16 (Day) 1859 (Year)

7. AGE: 54 Yrs. 16 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Calvin Robinson

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Margaret Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Calvin Robison

(Address) Kuna Idaho

15. Filed June 23 1914

C. L. Dutton
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1914, to June 22 1914, that I last saw him alive on June 21 1914, and that death occured on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Liver

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Toxaemia & Exaustion

(Duration ..... yrs. ..... mos. 14 ds.

(Signed) Thomas N. Brayton M. D.

June 23 1914 (Address) Empire Bldg Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho. DATE OF BURIAL: June 23 1914

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 8284
Registered No.

1. PLACE OF DEATH.
County of Ada
City of near 5 Mile School (No. near 5 Mile School St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ross Thompson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 19th (Day) 1903 (Year)

7. AGE: 10 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nebr.

10. NAME OF FATHER Wm Thompson

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Ida Easton

13. BIRTHPLACE OF MOTHER (State or Country) Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Wartman
(Address) Meridian R.D. 2.

15. Filed June-16-1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 14th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June-12th 1914, to June-14- 1914, that I last saw him alive on June-14- 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows: Meningitis
Malignant Cerebrospinal Meningitis (Epidemic type)
(Duration) — Yrs. mos. ds.
Contributory (Secondary) Do not know
(Duration yrs. mos. ds.
(Signed) M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Ada County, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Joplin Cemetery — DATE OF BURIAL: 6/15 1914

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD-YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8285

Registration District No. 2
Primary Registration District No. 1004

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1th Telephone St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Frost

Registered No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 34 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Frost

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Archer

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Frost
(Address) Vale Oregon

15.
Filed 5-19 1914
W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 19th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 13 1913, to death 1914, that I last saw h alive on evening May 18th 1914, and that death occured on the date stated above, at 5:20 a M.

The CAUSE OF DEATH* was as follows:
Cancer of Larynx
(Duration) about Yrs. 8 mos. ds.
Contributory (Secondary) Obstruction of trachea
(Duration) about Yrs. 2 mos. ds.
(Signed) W. E. Massey M. D.
7/19 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Vale Ore. DATE OF BURIAL: 5-20 1914

20. UNDERTAKER: Schmuck & Sedgwick ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 R. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8049
Registered No. 8289

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. (or 4)

(No. St. Lukes Hospital)

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William W. Bryden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 4 (Month) (Day) 1885 (Year)

7. AGE: 29 Yrs. 2 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Printer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John W Bryden

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia

12. MAIDEN NAME OF MOTHER: Mary Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Peter D Bryden
(Address): 211-13 and Nampa Ida.

15. Filed 5-18 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 17 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1914, to May 17 1914, that I last saw h[illegible] alive on May 17 1914, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pyaemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M D Bryden M. D.

5/17 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellview Idaho. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8290
Registered No. 8290

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 315 E Jefferson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Francis Cross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 15 (Day) 1833 (Year)

7. AGE: 81 Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hanover N. H.

10. NAME OF FATHER: Timothy Cross.

11. BIRTHPLACE OF FATHER (State or Country): ~~Do~~ N. H.

12. MAIDEN NAME OF MOTHER: Adeline Kent

13. BIRTHPLACE OF MOTHER (State or Country): N. H.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adelaide M Cross
(Address) 315 E Jefferson Boise Ida

15.
Filed 5-4 1914
M S Parker
Local Registrar

6Y98 - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 4th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/2 1914, to 5/4 1914, that I last saw h-m alive on 5/4 1914 and that death occured on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:
Senility
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Fred A Bellinger M. D.
5/4 1914 (Address) Talk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence 315 E Jefferson Boise Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: 5/5 1914

20. UNDERTAKER: Schreiber & Sadtler
ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ..... St.)

File No. 8291
Registered No. 8291

1. PLACE OF DEATH.
County of Washington
City of Midvale
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Enoch Edson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Nov 12 – 1859
(Month) (Day) (Year)

7. AGE 57 Yrs. 7 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER E. G. Edson

11. BIRTHPLACE OF FATHER (State or Country) Newyork

12. MAIDEN NAME OF MOTHER Mary Garrison

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elmer Edson
(Address) Midvale Idaho

15. Filed June 10 1914 H. E. Snyder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1913, to June 9 1914, that I last saw h[illegible] alive on June 9 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) 1 Yrs. 9 mos. – ds.
Contributory (Secondary) Aortic aneurism
(Duration ? yrs. ? mos. ? ds.

(Signed) W. W. Marshall M. D.
June 10 1914 (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt Pleasant Ida — DATE OF BURIAL June 10 1914

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington — Registration District No. 87

City of Midvale — Primary Registration District No. 2154

(No. ....., ... St.)

File No. 8202

Registered No. 8202

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo Allen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. March (Month) 9 (Day) 1836 (Year)

7. AGE: 78 Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Warren Allen.

(Address) Midvale Ida.

15. Filed July 9 1914 — H E Snyder, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Bullet wound in head self inflicted

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Houston & Snyder M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Galbraith — DATE OF BURIAL: July 9 1914

20. UNDERTAKER: Ray — ADDRESS: Midvale

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8293

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Midvale

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

2. FULL NAME Rosa Randleman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) - 4 (Day) - 1879 (Year)

7. AGE: 34 Yrs. 8 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington County, Ida

10. NAME OF FATHER G S Keithly

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Maggie Keithly (Name same as father)

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. L. Keithly

(Address) Midvale Ida

15. Filed June 6 1914 H E Snyder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1914, to June 6 1914, that I last saw her alive on June 6 1914, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia Convulsions

Convulsions 6 weeks Previous

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Fatty Degenerate Heart

..... (Duration 10 yrs. ..... mos. ..... ds.

(Signed) Edward Ball M. D.

June 6 1914 (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: M W Pleasant — DATE OF BURIAL: June 7 1914

20. UNDERTAKER — ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

File No. 8201

Registered No. .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Maria Christina Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 2 (Day) 1840 (Year)

7. AGE: 73 yrs. ..... mos. 5 ds. 14
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Anders Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER. Anna unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August Larson
(Address) Troy Idaho

15.
Filed Apr 16 1914 C. V. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at 9 9. M.

The CAUSE OF DEATH* was as follows:
Heart Failure — Complained during night of pain in left side of chest and left shoulder. Died sitting on edge of bed.
..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Olson M. D.
April 14 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge Cemetary — DATE OF BURIAL: April 17 1914

20. UNDERTAKER: August Larson — ADDRESS: Troy Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

File No. 8205
Registered No. .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Clarence Arnold Phipps.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 4th (Day) 1911 (Year)

7. AGE: 2 yrs. 9 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Tacoma Wash

10. NAME OF FATHER: Wm. Phipps.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Elsie Shuffler

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Phipps
(Address) Troy Idaho

15.
Filed Apr 21 1914 C V Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1914, to apr 19 1914 that I last saw him alive on apr 19 1914 and that death occurred on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:
Follicular Tonsilitis and Pyonephritis

..... (Duration) ..... yrs. ..... mos. 14 ds.
Contributory (Secondary) Obstruction of bowels
..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J V Watson M. D.
4/20 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge Cemetery DATE OF BURIAL: April 21 1914

20. UNDERTAKER: Frank C. Swanson ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ..... St.)

File No. 8296
Registered No. .....

2. FULL NAME. John Oscar Fredrickson
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1889 (Year)

7. AGE: 24 yrs. 10 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farm laborer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Clay Co. Minn

10. NAME OF FATHER: Carl E Fredrickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Karen Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sophie Fredrickson
(Address) Troy Idaho

15. Filed June 11 1914 C. V. Johnson Local Registrar
per J. W. O.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 10 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 1912., to June 10 1914
that I last saw him alive on May 26 1914
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
Caused by Rheumatic fever
..... (Duration) 5 yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Parenchymatous Nephritis
..... (Duration) ..... yrs. 3 mos. ..... ds.
(Signed) J. W. Olson M. D.
June 11 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge Cem. Troy Ida.
DATE OF BURIAL: June 17 1914

20. UNDERTAKER: Peter Swerson
ADDRESS: Troy Idaho

BYRD-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8297
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Annie Mary Grant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 4 (Day) 1853 (Year)

7. AGE: 60 yrs. 11 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Peter Landgren

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Grant
(Address) Troy Idaho

15. Filed June 15 1914 C. V. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1908, to June 13 1914
that I last saw her alive on June 13 1914
and that death occurred on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymentous Nephritis

..... (Duration) 6 yrs. ..... mos. ..... ds.
Contributory (Secondary) Uraemia
..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) C. V. Johnson M. D.
June 15 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetary Troy Idaho
DATE OF BURIAL: June 16 1914

20. UNDERTAKER: Mrs Chas. Johnson
ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8299
Registered No.

1. PLACE OF DEATH. Registration District No. 64
County of Latah Primary Registration District No. 2144
City of Troy (No. Howard St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Elizabeth Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 21 (Day) 1880 (Year)

7. AGE: 34 yrs. 2 mos. 30 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: J. C. Sly

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Elizabeth Sly

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. W. Johnson
(Address) Troy Idaho

15. Filed June 20 191 E. W. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1914., to June 19 1914
that I last saw h[illegible] alive on June 19 1914
and that death occurred on the date stated above, at 10.15 P. M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from Placenta Previa.

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Dobson M. D.
June 20 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burbank Cemetery — DATE OF BURIAL: June 21 1914

20. UNDERTAKER: Mrs D Armstrong — ADDRESS: Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8301
Registered No.

1. PLACE OF DEATH.
Registration District No. 04
County of Latah
Primary Registration District No. 2144
City of Troy (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Elma Daisy McGarvey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: January 11 (Month) 1914 (Day) (Year)
7. AGE: — yrs. 5 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Robt. William McGarvey
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Rose Wood
13. BIRTHPLACE OF MOTHER (State or Country): Iowa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rose McGarvey
(Address) Troy Idaho
15.
Filed June 29 1914 C. F. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 27 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 27 1914, to June 27 1914
that I last saw her alive on June 27 1914
and that death occurred on the date stated above, at 3:15 P.M.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

— (Duration) — yrs. — mos. 10 ds.
Contributory (Secondary): Gastro-enteritis
(Duration) — yrs. — mos. 5 ds.
(Signed) Jno. McCall M. D.
June 27 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. 5 mos. 16 ds. In the State — yrs. 5 mos. 16 ds.
Where was disease contracted, if not at place of death? Troy Idaho
Former or usual residence Troy Idaho

19. PLACE OF BURIAL OR REMOVAL: Cornwall Cemetery DATE OF BURIAL: June 29 1914
20. UNDERTAKER: Mrs D Armstrong ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida

City of Samaria

Registration District No. 21

Primary Registration District No. 2069

(No. ..... St.)

File No. 8302

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ben Waldron

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. (Month) 18 (Day) 1853 (Year)

7. AGE: 60 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Salt Lake City Ut.

10. NAME OF FATHER: Benjuman Waldron

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Emeline Savage

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emeline Thomas

(Address) Pleasant View Idaho

15. Filed 4-24 1914

D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 29 1914, to Apr 13 1914, that I last saw h[illegible] alive on April 13 1914, and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Oedema of glottis

.....(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Acute Brights disease

.....(Duration ..... yrs. ..... mos. 20 ds.

(Signed) D C Ray M. D.

4-24-1914 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Samaria Idaho.	April 16 1914
20. UNDERTAKER	ADDRESS
D. E. Johnson	Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

26

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2069

(No. , St.)

File No. 8303

Registered No. 11

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William E Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: 2 (Month) 19 (Day) 1848 (Year)

7. AGE: 66 yrs. 1 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miller
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Wm Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Eleanor Evans

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lucretia Jones
(Address): Malad City Ida

15. Filed 4-17 1914 H C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1914, to Apr 16 1914, that I last saw him alive on Apr 16 1914 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D C Ray M. D.

4 17 1914 (Address) Malad City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — DATE OF BURIAL: 4-19 1914

20. UNDERTAKER: D E Johnson — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2069

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8204

Registered No. 12

1. PLACE OF DEATH.
County of Oneida
City of Malad.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Owen Daniel Ward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	wh	

6. DATE OF BIRTH
July. 18. 1910
(Month) 2 (Day) (Year)

7. AGE
3 yrs. 10 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Woodruff Idaho.

10. NAME OF FATHER Charles William Ward

11. BIRTHPLACE OF FATHER
(State or Country) Oneida County Ida

12. MAIDEN NAME OF MOTHER Sarah Sophia Jones

13. BIRTHPLACE OF MOTHER
(State or Country) Oneida County. Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles W. Ward.
(Address) Malad Idaho.

15.
Filed 4-21 1914 L C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April. 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at 5.45 P. M.
The CAUSE OF DEATH* was as follows: Physicians Certificate and Coroners Evidence
accidental drowning

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L C Ray M. D.
4-21 1914 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida	4-22 1914

20. UNDERTAKER	ADDRESS
L E Johnson	Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2064
(No. ..... St.)

File No. 8305
Registered No. 18

1. PLACE OF DEATH.
County of Oneida
City of Samaria

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Price

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 23 (Day) 1894 (Year)

7. AGE: 19 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Post Mistress
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Samaria, Idaho

10. NAME OF FATHER Daniel E. Price

11. BIRTHPLACE OF FATHER (State or Country) South Wales

12. MAIDEN NAME OF MOTHER Mary Jenkins

13. BIRTHPLACE OF MOTHER (State or Country) South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Daniel E. Price
(Address) Samaria Ida

15.
Filed 5-5 1914 D C Ray Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1913, to May 4 1914, that I last saw h.er alive on May 4 1914, and that death occured on the date stated above, at 9:50 M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) 1 Yrs. mos. 1 ds.
Contributory (Secondary) Chronic Bright's disease
(Duration 2 yrs. mos. ds.

(Signed) D C Ray M. D.
5/6 1914 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria, Idaho — DATE OF BURIAL: May 7 1914

20. UNDERTAKER: D. S. Johnson — ADDRESS: Malad Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 8306
Registered No. 94

1. PLACE OF DEATH.
County of Oneida
City of St. John

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept (Month) 4 (Day) 1900 (Year)

7. AGE: 13 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): St John Oneida county Idaho

10. NAME OF FATHER: Matthew Hill Jr.

11. BIRTHPLACE OF FATHER (State or Country): Oneida County Idaho

12. MAIDEN NAME OF MOTHER: Elizabeth Hutchinson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Matthew Hill Jr
(Address) St John Oneida County Idaho

15. Filed 5-13 1914 D C Roy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1914 to May 14 1914, that I last saw her alive on May 12 1914 and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) J F Clinton M. D.

5/16 1914 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St John Idaho. DATE OF BURIAL: May 17 1914

20. UNDERTAKER: W S Johnson ADDRESS: Malad Ida

STYLUS - YORK CO., PTRS. & STNRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8307

Registered No. 15

1. PLACE OF DEATH.

County of Oneida

City of Holbrook

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marva Dunn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 7 (Day) 1914 (Year)

7. AGE: Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Holbrook Idaho

10. NAME OF FATHER: Frank Dunn

11. BIRTHPLACE OF FATHER (State or Country): Perry, Utah

12. MAIDEN NAME OF MOTHER: Mary Nichlos

13. BIRTHPLACE OF MOTHER (State or Country): Kintuckey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Casand Dunn

(Address) Holbrook, Idaho

15. Filed 5-18 1914

DC Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows: No Physican in Attendance
Acute Indigestion

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) DC Ray M. D.

5-18 1914 (Address) Malad City, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Holbrook Idaho — DATE OF BURIAL: May 21 1914

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8208

Registered No. 16

Registration District No. 26

Primary Registration District No. 2069

1. PLACE OF DEATH.

County of Oneida

City of St John

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harrel Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH. May (Month) 18 (Day) 1907 (Year)

7. AGE: 7 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oneida County Ida

10. NAME OF FATHER: David J Lewis

11. BIRTHPLACE OF FATHER (State or Country): Oneida County Ida

12. MAIDEN NAME OF MOTHER: Maud J Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis Lewis

(Address) St John Idaho

15.

Filed 2-19 1914

N C Berg
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/18 1914, to 5/18 1914, that I last saw him alive on ..... 191~, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Drug by hand of unknown
that failed to be Conclusive.

~ (Duration) ~ Yrs. ~ mos. ~ ds.

Contributory (Secondary) .....

~ (Duration) ~ yrs. ~ mos. ~ ds.

(Signed) J M Rice M. D.

2-19 1914 (Address) St Charles

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Idaho — DATE OF BURIAL: May 21 1914

20. UNDERTAKER: W S Johnson — ADDRESS: Malad.

[redacted]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

8309

City of Malad (No. ..... St.) Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza R. Dredge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: June (Month) 14 (Day) 1880 (Year)

7. AGE: 33 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bear Lake County Idaho

10. NAME OF FATHER: John Kunz

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: M Burkhardt

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Dredge.

(Address) Malad City Idaho

15. Filed 5-21 1914 D C Ray Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to May 20 1914, that I last saw her alive on May 20 1914, and that death occured on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Peri Endo Cardits

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.

5-21 1914 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho

DATE OF BURIAL: May 23 1914

20. UNDERTAKER: W E Johnson

ADDRESS: Malad Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

File No. 8310
Registered No. 18
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Teli T Howard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	Wh	

6. DATE OF BIRTH: Feb (Month) 24 (Day) 1904 (Year)

7. AGE: 10 yrs. 4 mos. ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Thos W. Howard

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ruth Talbot

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T W Howard
(Address) Malad Ida

15. Filed 7-26 1914 L C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 3.30 M.

The CAUSE OF DEATH* was as follows:
Accidental by suffocating Covered with load of hay in runaway
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) ..... no physician in attendance
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L C Ray M. D.
6-26 1914 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida	6-27 1914

20. UNDERTAKER	ADDRESS
L C Johnson	Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Marsh
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2064
(No. ..... , ... St.)

File No. 8311
Registered No. 19
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Sarah Ann Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: May (Month) 20 (Day) 1898 (Year)

7. AGE: 16 yrs. 1 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo Morgan

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Virginia Nickles

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. J. Morgan
(Address) Malad Oneida Co Ida

15. Filed 7-1 1914 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1914 to June 30 1914 that I last saw her alive on June 29 1914, and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Alton M. D.
7-1 1914 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: July 3 1914

20. UNDERTAKER: D E Johnson — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2146
(No. ..... St.)

File No. 8312
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Bovill
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pete Isaacson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) ..... (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Potlatch Lum. Co.

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) —
(Address) —

15. Filed 7/8/ 1914 F.G. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 — 4 — 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191—, that I last saw h— alive on — 191—, and that death occured on the date stated above, at 2:20 M.

The CAUSE OF DEATH* was as follows:

Suffocation.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Burns & bruises.

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. C. Gibson M. D.

7/8/1914 (Address) Bovill.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill. DATE OF BURIAL: 7/9/ 1914

20. UNDERTAKER: J. L. Shamplin ADDRESS: Bovill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2146
Primary Registration District No. 66
File No. 8313
Registered No. ____

1. PLACE OF DEATH.
County of Latah
City of Bovill
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe M. Shaffer.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.
6. DATE OF BIRTH. — (Month) — (Day) — (Year)
7. AGE: 40 Yrs. — Mos. — ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): —
10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) —
(Address) —
15. Filed 7/8/ 1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 — 8 — 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from — 191__, to — 191__, that I last saw h— alive on — 191__, and that death occured on the date stated above, at 2:30 M.
The CAUSE OF DEATH* was as follows:
Suffocation -
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) Burning Building -
(Duration ____ yrs. ____ mos. ____ ds.
(Signed) H. Gibson M. D.
7/6 1914 (Address) Bovill.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bovill — DATE OF BURIAL: 7/5/ 1914
20. UNDERTAKER: J. L. Champeine — ADDRESS: Bovill.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2051
(No. ..... St.)

File No. 8314
Registered No. 421
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Nesbitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
49 yrs. ..... mos. ..... ds.
Absent
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Day Labr
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Cal.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) — Ireland

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) St Mon's
(Address) Rathdrum

15.
Filed 9/10 1914 D. F. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to June 30 1914, that I last saw h alive on 6 30 1914 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Bowels

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. F. Brennan M. D.
9/2 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? St Mon's Idaho
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rathdrum | DATE OF BURIAL 9/3 1914

20. UNDERTAKER Kloty | ADDRESS Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8315

Registered No. 420

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 17

County of Kootenai, Primary Registration District No. 2057

City of Rathdrum ~~RFD~~ (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marian Good

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	S

6. DATE OF BIRTH September 16th 1 (Month) (Day) (Year)

7. AGE 18 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wisconsin Buffalo Co.

10. NAME OF FATHER J S Good

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania Lancaster Co

12. MAIDEN NAME OF MOTHER Orpha Seger

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin Dunn Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Simon Beck
(Address) Rathdrum Idaho

15. Filed 7/10 1914 S S Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 26 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
No 1 Pulmonary Tuberculosis
No Dr. at Death

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Freeman M. D.
6/28 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rathdrum | DATE OF BURIAL 6/28 1914

20. UNDERTAKER Simon Beck | ADDRESS Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 . 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 14

Primary Registration District No. 2051

File No. 8317

Registered No. 418

County of Kootenai

City of Rathdrum (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	widow

6. DATE OF BIRTH: June (Month) 25. (Day) 1825 (Year)

7. AGE: 88 yrs. 11 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: George Choate

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Stella

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha Saunders
(Address) Rathdrum, Ida.

15.
Filed 7-10 — 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9. 1914, to June 16. 1914, that I last saw her alive on June 15. 1914, and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Gastritis

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile decay

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wenz M. D.

6/17. 1914. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum — DATE OF BURIAL: 6/17 1914

20. UNDERTAKER: C E Bolo Mgr Sons — ADDRESS: Rathdrum Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2051
(No. ....., ... St.)

File No. 8318
Registered No. 417
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Byron E. Green

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	M

6. DATE OF BIRTH: June (Month) 24 (Day) 1869 (Year)

7. AGE: 44 yrs. 11 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kans

10. NAME OF FATHER Sylvanus Green

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER Lucy A Goss

13. BIRTHPLACE OF MOTHER (State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. E. Green
(Address) Rathdrum Idaho

15. Filed 7/10 1914 A. D. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Died suddenly a Doctor
was a sleep.
Suddenly. Acute Lung Trouble
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Bronchitis
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Dyegaard M. D.
6/9 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum Cemetery	June 11, 1914

20. UNDERTAKER ..... ADDRESS .....

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum (No. ....., St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2051

File No. 8319
Registered No. 416
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amelia Nicolai

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: January 26th 1857
(Month) (Day) (Year)

7. AGE: 57 yrs. 4 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Henry Brinkman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur W. Nicolai
(Address) Rathdrum Ida.

15. Filed 7/10 1914 D D Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 8th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8. 1914, to June 8. 1914, that I last saw her alive on June 8. 1914, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Apoplexy.)
(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Arterio sclerosis
(Duration) about 2 yrs. ..... mos. ..... ds.

(Signed) Frank Wang M. D.
6/10 1914. (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Cem. | DATE OF BURIAL: 6/11 1914

20. UNDERTAKER: [signature] | ADDRESS: Rathdrum.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1014

County of Gooding Primary Registration District No. 2014

File No. 8320

City of S.W. Gooding (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Harold Hafer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	S

6. DATE OF BIRTH June (Month) 1 (Day) 1914 (Year)

7. AGE ..... yrs. ..... mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ralph Hafer

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Minnie Welch

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Hafer
(Address) Gooding Ida.

15. Filed July 11— 1914 T. V. Carey M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1914, to June 7th 1914
that I last saw h.e alive on June 7 1914
and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Streptococcus

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Mal Nutrition

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) C. J. Douglass M. D.

19 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Gooding Idaho | DATE OF BURIAL June 9 1914

20. UNDERTAKER No— | ADDRESS

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gooding — Registration District No. 1014
City of Gooding — Primary Registration District No. 2014
(No. ....., ... St.)
File No. 8321
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Reed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: Unknown ..... 1 ..... (Month) (Day) (Year)

7. AGE: 57 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) ..... None

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A E Thompson
(Address) Gooding Ida

15.
Filed July 15 1914 F. T. Carey M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 23 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1914, to June 23 1914, that I last saw h[illegible] alive on June 15 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Chronic Brights Disease

..... (Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....
..... (Duration) ? yrs. ..... mos. ..... ds.

(Signed) F. T. Carey M. D.
July 15 1914 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: July 13 1914

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 1014

Primary Registration District No. 2014

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8322

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Grant Reffner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 4 (Day) 1913 (Year)

7. AGE: .....Yrs. 10 Mos. 18 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Gooding Idaho

10. NAME OF FATHER: Joseph Reffner

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Daisy Faber

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss J. Reffner

(Address) Gooding Idaho

15.

Filed July 21 1914

F. T. Carey M.D.
Local Registrar

SYMS - YORK CO., PTRS. & PORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1914, to Feb 22 1914, that I last saw him alive on Feb 21 1914, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Muco Colitis

.....(Duration) .....Yrs. .....mos. 5 ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds

(Signed) F. T. Carey M.D. M.

July 20, 1914 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding

DATE OF BURIAL: Feb. 24 1914

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8323
Registered No.

1. PLACE OF DEATH. Registration District No. 1014
County of Gooding Primary Registration District No. 2014
City of Gooding (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Wm N. Fulton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH: May (Month) ... (Day) 1851 (Year)
7. AGE: 63 yrs. ... mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.
8. OCCUPATION
(a) Trade, professsion, or particular kind of work: School Teacher
(b) General nature of industry business, or establishment in which employed (or employer): Farming
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S. Simpson
(Address) Salt Lake City
15.
Filed July 10 1914 F. T. Carey M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 29 1914, to May 8 1914
that I last saw him alive on May 8th 1914,
and that death occurred on the date stated above, at 5.40 P.M.
The CAUSE OF DEATH* was as follows:
Spotted fever
(Duration) ... yrs. ... mos. 14 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) J H Cromwell M. D.
May 8 1914 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Salt Lake City Ut
DATE OF BURIAL ... 1914
20. UNDERTAKER: E A Thompson
ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8324

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.,
County of Goodding
City of Bliss
(No. , St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Infant) Pinkham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Infant

6. DATE OF BIRTH: May (Month) 30 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 6 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bliss Ida.

10. NAME OF FATHER: Chas Pinkham

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Ada Pence

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J H Cromwell
(Address) Gooding

15.
Filed July 15 1914 T. T. Cary M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 191..., to May 30 1914
that I last saw h[illegible] alive on May 30 1914,
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Spasm -

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Mother had Eclampsia

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J H Cromwell M. D.
19... (Address) Gooding Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bliss Ida
DATE OF BURIAL: June 1914

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

FORM V. S. No. 5-35 M. 1-16-15

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2046
(No. ....., ... St.)

File No. 8326
Registered No. 30

1. PLACE OF DEATH.
County of Bannock
City of Oxford

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel Ida Abel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single Married

6. DATE OF BIRTH.
Jan (Month) 1 (Day) 1 (Year)

7. AGE
24 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) House keeper

9. BIRTHPLACE
(State or Country) Ogden, Utah.

10. NAME OF FATHER Obed Abel

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Mary Ann O'Keefe

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Obed Abel
(Address) Oxford Idaho

15.
Filed July 10, 1914 Eva Kaser Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1914, to June 8 1914, that I last saw her alive on April 30 1914, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Myocarditis.
Hemophilia

(Duration) Yrs. 3 mos. 8 ds.

Contributory (Secondary) none

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. W. B. Parkinson M. D.
19..... (Address) Lewiston Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Utah	June 10 1914
20. UNDERTAKER Walter Hatch	ADDRESS Oxford Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sde Spring
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048
(No. ..... , ... St.)

File No. 8327
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis Hayman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH
July (Month) 15 (Day) 1871 (Year)

7. AGE
42 yrs. 11 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Worker
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Lewis Hayman

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Jane Cannyl

13. BIRTHPLACE OF MOTHER
(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ranch Chief - Nurse
(Address) Sde Spring, Idl

15.
Filed Jan 9th, 1914 Edw Kelly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 4, (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1914, to July 4 1914, that I last saw her alive on July 4, 1914 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Lobar right)
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory Nurse
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edw Kelly M. D.
July 4 1914 (Address) Sde Spring

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon — DATE OF BURIAL: June 6 1914

20. UNDERTAKER: O G Crawford — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 8327

Name (?)

Date of Death July 4. 1914

Cause of Death Lobar, Right Pneumonia

Contributary Cause of death None

(Sign here) Ellis Earley M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Chesterfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2047
(No. ..., ... St.)

File No. 8328
Registered No. 22

2. FULL NAME Francis Whitworth

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
May (Month) 9 (Day) 1880 (Year)

7. AGE
33 yrs. 11 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER George Whitworth

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Wheatley

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T. Whitworth
(Address) Chesterfield, Ida

15.
Filed June 10, 1914 Ellis Carey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~191..., to~~ 191..., that I last ~~saw h~~ alive on 191..., and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Lightning Stroke

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) R. Keith M. D.
5 June 1914 (Address) Bancroft.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chesterfield	May 20 1914
20. UNDERTAKER	ADDRESS
C. C. Johnson	Bench

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of McCammon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2047
(No. ....., ... St.)

File No. 8329
Registered No. 21
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mads Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 14 (Day) 1914 (Year)

7. AGE: 89 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Christen Anderson

11. BIRTHPLACE OF FATHER (State or Country): Danmark

12. MAIDEN NAME OF MOTHER: Marie Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hannah M. Christensen
(Address) Robin Idaho

15. Filed June 10 1914 Ellis Caley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) — 14 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h— alive on ——— 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
——— Probably — Heart Disease
Information given by son. —
— never saw deceased —

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) ..... M. D.
19.... (Address) ..... per —

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon | DATE OF BURIAL: 6-16-1914

20. UNDERTAKER: W. H. Walker | ADDRESS: Inkwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2047
File No. 8320
Registered No. 29

1. PLACE OF DEATH.
County of Bannock
City of McCammon — (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME McKinnon.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Armenian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't Know.
6. DATE OF BIRTH. (Month) Don't Know (Day) 1 (Year)
7. AGE: about 30 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Don't Know
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (State or Country): Don't Know.
12. MAIDEN NAME OF MOTHER: Don't Know.
13. BIRTHPLACE OF MOTHER (State or Country): Don't Know
14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) G. A. Cox
(Address) McCammon Ida.
15. Filed July 10, 1914 Ellis Kaucher Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: about April (Month) (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration — yrs. — mos. — ds.
(Signed) G. A. Cox M. D.
19.... (Address) McCammon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon, Ida. DATE OF BURIAL: July 12 1914

20. UNDERTAKER: Walker Russell ADDRESS: Pocatello Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 116

Primary Registration District No. 2185

File No. 8331

County of Bingham

City of Aberdeen (No. ....., ... St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Fast

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 29 (Month) (Day) 1914 (Year)

7. AGE: — yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.? 9

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Peter Fast

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Katherin Becker

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Fast
(Address) Aberdeen Ida

15.
Filed Jun 23 191 4 Mernon Tinney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 22 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22nd 1914, to June 22 1914 that I last saw her alive on June 22nd 1914 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia (7 months)
Fever 9 days

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard T. Wood M. D.
6/23 1914 (Address) Cemeteau Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mennonite Cimetery — DATE OF BURIAL: June 23 1914

20. UNDERTAKER: Peter Fast acting — ADDRESS: Aberdeen Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116
Primary Registration District No. 2165
(No. ....., ... St.)

File No. 8933
Registered No. 17
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helena Roloff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
May 24 1906
(Month) (Day) (Year)

7. AGE
8 yrs. — mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... School girl
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) ~~Ida~~ Russia

10. NAME OF FATHER Gottfried Roloff

11. BIRTHPLACE OF FATHER
(State or Country) Russia

12. MAIDEN NAME OF MOTHER Maria Knodel

13. BIRTHPLACE OF MOTHER
(State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gottfried Roloff
(Address) Aberdeen Idaho

15.
Filed June 2 1914 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 1 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1914, to June 1 1914
that I last saw h[illegible] alive on May 31 1914
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) ..... yrs. 2 mos. — ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Jan 2 1914 (Address) Aberdeen Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
German memorial Cemetery	June 3 1914

20. UNDERTAKER acting	ADDRESS
E. Ruff	Aberdeen Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 116

Primary Registration District No. 2195

File No. 8524

Registered No. 76

County of Bingham

City of Aberdeen (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willie Emms

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

..... (Month) ..... (Day) 1903 (Year)

7. AGE

11 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER Frank D. Emms

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Katie Harder

13. BIRTHPLACE OF MOTHER (State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank D. Emms

(Address) Aberdeen Ida

15.

Filed June 1 1914 W. McNaughton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1914 to May 31 1914 that I last saw h. alive on May 31 1914 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Endo & Peri-Carditis

(Duration) ..... yrs. 5 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. McNaughton M. D.

June 1 1914 (Address) Aberdeen

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Aberdeen Cemetery | DATE OF BURIAL June 2 1914

20. UNDERTAKER F. D. Emms | ADDRESS Aberdeen

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Howe
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139

File No. 4 8335
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Cecil Stevens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1909 (Year)

7. AGE: 4 yrs. 8 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blaine, Idaho

10. NAME OF FATHER: Frank J. Steven

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Effie Thornton

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. J. Steven
(Address) Howe Ida

15. Filed 4/26 1914 E. W. Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/25 1914, to 4/25 1914 that I last saw h— alive on 4/25 1914 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Poisoned from eating wild parsnip
2 hours
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Fox M. D.
4/26 1914 (Address) Arco Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Howe Idaho
DATE OF BURIAL: 4/27 1914

20. UNDERTAKER: F. Steven
ADDRESS: Howe, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Arco
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

File No. 9
Registered No. 8336
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ruthie Parsons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widowed
6. DATE OF BIRTH: May 20 1842 (Month) (Day) (Year)
7. AGE: 72 yrs. 16 mos. ..... ds. IF LESS than 1 day how many ..... *hrs.or* ..... *min.?*
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Arkansas
10. NAME OF FATHER: John Brumblow
11. BIRTHPLACE OF FATHER (State or Country): Georgia
12. MAIDEN NAME OF MOTHER: Mary Griffins
13. BIRTHPLACE OF MOTHER (State or Country): Illinois
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs O B. Hurst
(Address) Arco, Idaho
15.
Filed June 8 1914 Ew Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
General Senility
Mitral Desion of heart
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ew Fox M. D.
6/8 1914 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho
DATE OF BURIAL: 6-8- 1914
20. UNDERTAKER: Oscar Hurst
ADDRESS: Arco Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Jefferson. Primary Registration District No. 2139
City of Howe (No. ....., ... St.)
File No. 10
Registered No. 8337

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Helen Hafsmith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 25 (Day) 1872 (Year)

7. AGE: 41 yrs. 11 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lincoln, Nebraska

10. NAME OF FATHER: Joe Hagert

11. BIRTHPLACE OF FATHER (State or Country): Liverpool England

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Hafsmith
(Address) Howe, Idaho

15.
Filed June 15 1914 Lew Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191...
that I last saw h~ alive on ~ 191...,
and that death occurred on the date stated above, at ~ M.

The CAUSE OF DEATH* was as follows:
Suicide - Strychnine poisoning

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

6/6 1914 (Address) Lew Fox M.D. Howe-Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Howe, Idaho — DATE OF BURIAL: June 8 1914

20. UNDERTAKER: E. B. Jones — ADDRESS: Howe, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Ericc

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

File No. 11
Registered No. 8338

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Alfred Alexander Brim

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) ... (Day) 1848 (Year)

7. AGE: 66 yrs. ... mos. ... ds.
IF LESS than 1 day how many ..... hrs.or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Alexander Brim

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Anna M. Bishop

13. BIRTHPLACE OF MOTHER (State or Country): Greece, N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William F. Brim
(Address) Oakley - Utah

15. Filed 6/13 1914 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suicide - Hanged by neck - rope

..... (Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
..... (Duration) ... yrs. ... mos. ... ds.

(Signed) E W Fox M. D.
6/13 1914 (Address) Arco - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Martin, Idaho
DATE OF BURIAL: 6/13 1914

20. UNDERTAKER: Bert Brim
ADDRESS: Martin Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: *(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Form V. S. No. 5. Rev. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Ketchum
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2439
(No. ....., ... St.)

File No. 12
Registered No. 8339
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs Elizabeth Ann Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: June (Month) 22 (Day) 1862 (Year)

7. AGE: 52 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Arnold Cuttler

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Agnus McGregor

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Cuttler
(Address) Salt Lake City, Utah

15. Filed 6/18 1914 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1914, to June 16 1914
that I last saw h er alive on June 16 1914,
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Cholecystitis
Duct Tumor probably acute
Congestion of Lungs.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Fox M. D.
6-18 1914 (Address) Ketchum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lehyde, Idaho — DATE OF BURIAL: 7-18 1914

20. UNDERTAKER: E. Williams — ADDRESS: Lehyde, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Arco
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

File No. 13
Registered No. 8340
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs. Maryann Page

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: August 23 (Month) (Day) 832 (Year)
7. AGE: 81 yrs. 9 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (State or Country): not known
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (State or Country): not known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ford M. Burtch
(Address) Arco, Idaho
15.
Filed June 20 1914 E W Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on June 3 1914,
and that death occurred on the date stated above, at 5 9 M.
The CAUSE OF DEATH* was as follows:
Gen. Senility
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James Monroe M. D.
19..... (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho — DATE OF BURIAL: 6/23 1914
20. UNDERTAKER: F. M. Burtch — ADDRESS: Arco, Ida

IVMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. ....., ... St.)
Registration District No. 70
Primary Registration District No. 101
File No. 8311
Registered No. 38
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME Infant Beardsley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. 1 hr
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Wallace
10. NAME OF FATHER: Loyd Beardsley
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Myrtle Spencer
13. BIRTHPLACE OF MOTHER (State or Country): Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. M. J. Spencer
(Address) Wallace Idaho
15. Filed June 1 1914 H. Leo Semple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h[illegible]ve on May 31 1914
and that death occured on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:
Congenital Atelectasis of Lungs
Premature birth
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature birth
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. D. Mowery M. D.
June 1 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: 6/1 1914
20. UNDERTAKER: Ward Undertaking — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 8312
Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Finley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1 (Year)
7. AGE: 26 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): New Foundland
10. NAME OF FATHER: Wm. Finley
11. BIRTHPLACE OF FATHER (State or Country): New Foundland
12. MAIDEN NAME OF MOTHER: Jane Kenney.
13. BIRTHPLACE OF MOTHER (State or Country): New Foundland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) William Finley Burke Ida
15. Filed June 2 1914 F. Leo Lingle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 191 4 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 6A M.
The CAUSE OF DEATH* was as follows:
Fell 1300 feet down shaft
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. A. Mowry M. D.
June 2 19 14 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida | DATE OF BURIAL: June 3 1914
20. UNDERTAKER: Ward Undertaking | ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE-JOHNK CO., PTRS. & BOOKB. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone
City of Wallace
(No. Wallace Hospital (St.)

Registration District No. 70
Primary Registration District No. 1011

File No. 8313
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans Becker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.

(Month) (Day) 1 (Year)

7. AGE

50 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hubert S. Mowery
(Address) Wallace Idaho

15.

Filed June 4 1914 H Leo Jungles
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. May (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to May 31 1914, that I last saw h.. alive on May 31 1914 and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows

Carcinoma Stomach & Liver

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Mowery M. D.
June 3 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Idaho	June 3 1914

20. UNDERTAKER	ADDRESS
B G Worstell	Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8314

Registered No. 47

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 72

Primary Registration District No. 6074

(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rufus Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 37 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Os. Anderson

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Polly Moore

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W Anderson

(Address) Wardner Ida

15. Filed June 6 1914 F Leo Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1914, to June 4 1914, that I last saw h[illegible] alive on June 3 1914 and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) — Yrs. — mos. 11 ds.

Contributory (Secondary) Arthritis ankle joint

(Duration) Yrs. 2 mos. ds.

(Signed) D W Mowry M. D.

June 6 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wardner, Idaho — DATE OF BURIAL: June 7 1914

20. UNDERTAKER: B G Norvell — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8345

Registered No. 4

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 78

Primary Registration District No. 6011

(No. Providence Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse Penney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 5, 1911 (Month) (Day) (Year)

7. AGE: three Yrs. ..... Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wardner, Shoshone Co., Idaho

10. NAME OF FATHER: William L. Penney

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Lindquist

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L. Penney

(Address) Wardner, Idaho

15. Filed June 12 1914 F. Leo Lund Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1914, to June 12 1914, that I last saw h[illegible] alive on June 11 1914, and that death occured on the date stated above, at 6:00 M.

The CAUSE OF DEATH* was as follows:

Tuberculer Meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

May 1914 (Address) Dr Mowry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 9 days. In the State 3 yrs. 0 mos. 7 days

Where was disease contracted if not at place of death? Kellogg Idaho

Former or usual residence Kellogg Idaho

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho

DATE OF BURIAL: June 13 1914

20. UNDERTAKER: Bruce G. Worstell

ADDRESS: Kellogg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8316

Registered No. 47

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Wallace Box P St.)

Registration District No. 70

Primary Registration District No. 1015

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin Lotze

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) 1 — (Year)

7. AGE: 39 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Saxony, Germany

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H B Mowery

(Address) Wallace Idaho

15. Filed 6/17 1914

Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1914, to June 11 1914, that I last saw him alive on June 11 1914 and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

3 (Duration) Yrs. mos. ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) June 13 1914 H. B. Mowery M. D.

(Address) Dr Mowery

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho

DATE OF BURIAL: 6/13 1914

20. UNDERTAKER: B G Mostell

ADDRESS: Wallace Id

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
File No. 8347
Registered No. 44

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Hope Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander E Mayhew

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 31 (Day) 1829 (Year)

7. AGE: 85 Yrs. 2 Mos. 15 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Philadelphia - Pa

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward E. Sanborn
(Address) Wallace Ida

15. Filed June 18 1914 F. Leo Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 19th 1913 to June 15 1914, that I last saw him alive on June 15 1914 and that death occured on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:
Cystitis
(Duration) 1 5 Yrs. 2 mos. ds.
Contributory (Secondary) Grand Mal
(Duration) 1 5 yrs. 4 mos. ds.
(Signed) Edward E. Sanborn M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 6 mos. 6 days. In the State 30 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? At Kendrick
Former or usual residence Wallace, Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: June 18 1914

20. UNDERTAKER: Bruce G Worden — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTGS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
File No. 8318
Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabetta L. Leonesio.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: girl
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October 29th 1900 (Month) (Day) (Year)

7. AGE: 13 Yrs. ..... Mos. 8 ds. 14
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Not any
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Butte, Montana

10. NAME OF FATHER: Pancy Leonesio.

11. BIRTHPLACE OF FATHER (State or Country): Italy.

12. MAIDEN NAME OF MOTHER: Mary Bottanini.

13. BIRTHPLACE OF MOTHER (State or Country): Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Pancy Nasei
(Address) Wallace Idaho

15. Filed June 15 1914 T. F. Leo Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1914, to June 13 1914, that I last saw h[illegible] alive on June 13 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Measles

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr. Mowery M. D.
6/15 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: June 16th 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8319
Registered No. 46

Registration District No. 70
Primary Registration District No. 104

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
57 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Indiana

10. NAME OF FATHER James Brooks

11. BIRTHPLACE OF FATHER
(State or Country) not Known

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Richard Roberts sr
(Address) Wardner Idaho

15.
Filed June 27 1914 F. Leo Zingley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1914, to June 22 1914, that I last saw h.er alive on June 21 1914 and that death occured on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:
Phlebitis femoral vein
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. Mowery M. D.
June 22 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 0 yrs. 0 mos. 22 days. In the State 35 yrs. — mos. — days
Where was disease contracted if not at place of death? Wardner
Former or usual residence Wardner Idaho

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: June 22 1914.
20. UNDERTAKER: Bruce L. Worstell — ADDRESS: Wallace Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8350

Registered No. 47

Registration District No. 76

Primary Registration District No. 101

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Erickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 16 (Day) 1874 (Year)

7. AGE: 38 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Eric Erickson

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wallace Ida

(Address) anne anderson

15. Filed June 23 1914 H Leo Dunbar Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/18/14 191..., to 6/19/14 191..., that I last saw him alive on June 19 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. 1 mos. 10 ds.

Contributory (Secondary) Odema of lungs

(Duration) 1 yrs. 11 mos. ..... ds.

(Signed) Frank C. Sharon M. D.

19..... (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Hosp.

At place of death ..... yrs. ..... mos. 6 days. In the State ..... yrs. 4 mos. ..... days

Where was disease contracted if not at place of death? Kellogg Mine

Former or usual residence Tamarack

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: June 25 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BANKS - YORK CO., PTPS. & BDGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 8351
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., R.F.D., St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur S. Hulbert.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	married

6. DATE OF BIRTH. Feb. (Month) 20 (Day) 1883 (Year)

7. AGE 31 Yrs. 3 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer and
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dairyman

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER J. S. Hulbert.

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Artemisia Lenora Spain

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. S. Hulbert
(Address) Nampa Idaho

15. Filed ..... 191.... Dr S D Calender Local Registrar
Anna Hatfield Deputy Reg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 2nd (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 a.m. 6/2/1914, to 6 a.m. 6/2/1914, that I last saw h.. alive on June 2nd 1914, and that death occured on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Accidental. Punctured wound in R. temporal region which entered brain.
(Duration) 0 Yrs. 0 mos. 0 ds.
Contributory (Secondary) None.
(Duration — yrs. — mos. — ds.
(Signed) Geo. O. A. Kelly M. D.
6/2/1914 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Id	6-6 1914

20. UNDERTAKER	ADDRESS
C. P. McCabe	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8252
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of
(No. , St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Clara H Selby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 10 (Day) 1842 (Year)

7. AGE: 71 yrs. 3 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: A. A. Dickenson

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm W Selby
(Address) Nampa Ida

15. Dr S D Calonage

Filed June 22 1914

Local Registrar Anna Hatfield Deputy Reg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191..., to 191...
that I last saw h... alive on 191...,
and that death occurred on the date stated above, at 10-A M.

The CAUSE OF DEATH* was as follows:
No Physician in attendance, She was paralyzed 25 yrs ago and has since gradually declined
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. D.
19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerdown Cem
DATE OF BURIAL: 6/22 191...

20. UNDERTAKER: H H Robinson
ADDRESS: Nampa

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8553
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Julia Lynch

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
— (Month) — (Day) 1850 (Year)

7. AGE: 64 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housekeeping
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: Hayes

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Don't know Judia Lynch

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Lynch
(Address) Nampa

15.
Filed July 8 1914 Wm S D Calonge
Local Registrar
Anna Hatfield Deputy Reg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1914, to July 1 1914
that I last saw her alive on July 1 1914,
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach

(Duration) yrs. 3 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W R Ross M. D.
July 7 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Kohlerdown Cem
DATE OF BURIAL: 7/8 1914

20. UNDERTAKER: F F Robinson
ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8854

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lester Earl C Culver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: Mar (Month) 23 (Day) 1908 (Year)

7. AGE: 6 yrs. 3 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J C Culver

11. BIRTHPLACE OF FATHER (State or Country): Nebr

12. MAIDEN NAME OF MOTHER: Susan B Center

13. BIRTHPLACE OF MOTHER (State or Country): Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Culver
(Address)

15. Filed July 12. 1914 W S D Calouge Local Registrar
Anna Hatfield Deputy Reg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1914, to July 9 1914
that I last saw him alive on July 9 1914,
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Meningitis

(Duration) yrs. mos. 1 ds.
Contributory (Secondary) Gastro enteritis
(Duration) yrs. mos. 5 ds.

(Signed) H P Ross M. D.
July 11 1914 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem
DATE OF BURIAL: 7/12 1914

20. UNDERTAKER: F B Robinson
ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

MARGIN RESERVED FOR BINDING
...RT; WITH UNFADING INK—THIS IS A PERMANENT RECORD.
...information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
...ld state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
...CUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8253
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Primary Registration District No.
City of Smiths Ferry (No., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Do not Know
6. DATE OF BIRTH: Do not know 1 (Month) (Day) (Year)
7. AGE: about 24 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): O.S.L.R.R. Co,
9. BIRTHPLACE (State or Country): Do not Know
10. NAME OF FATHER: Do not Know
11. BIRTHPLACE OF FATHER (State or Country): Do not Know
12. MAIDEN NAME OF MOTHER: Do not Know
13. BIRTHPLACE OF MOTHER (State or Country): Do not Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Hamilton
(Address) Nampa, Idaho,
15.
Filed July 28 1914 S.D. Calouge Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 26 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 191..., to 191...
that I last saw h... alive on 191...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Death from drowning
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) S.D. Calouge M. D.
7/28 1914 (Address) Nampa, Ida,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ... In the ... of death ... yrs ... mos ... ds. State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: Aug 1 1914
20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8356
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Canyon Primary Registration District No.
City of Nampa (No. , R F D , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie E Hagen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 14 (Day) 1876 (Year)

7. AGE: 37 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: House keeping
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Bro Oscar Arby

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. J. Hagen
(Address) Nampa Ida

15.
Filed Aug 2 1914 S D Coloney M D, Local Registrar
Anna Hatfield Deputy Reg.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1914, to July 31 1914
that I last saw her alive on July 31 1914,
and that death occurred on the date stated above, at 930 a. M.

The CAUSE OF DEATH* was as follows:
Emphigus

(Duration) yrs. mos. 30 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. P. Rose M. D.
Aug 1 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview Cem — DATE OF BURIAL: Aug 2 1914

20. UNDERTAKER: F C Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 8357
Registered No. 19

1. PLACE OF DEATH.
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Delia C Everton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 25 (Day) 1842 (Year)

7. AGE: 72 yrs. 1 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Duties
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Calvin Stiles

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Roxana Cheney

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cora H. Collyns
(Address) Mtn. Home, Idaho

15. Filed July 4th 1914 B.C. Mallatt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1914, to July 3 1914, that I last saw h[illegible] alive on July 3 1914 and that death occurred on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:
Rocky Mountain
Tick Fever

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... d

(Signed) W. L. Frazier M. D.
July 4 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... da
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blandfield Ill. DATE OF BURIAL 191

20. UNDERTAKER: J.M. Cowen ADDRESS Mountain Home

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF ~~DEATH~~.

Registration District No. 34

County of Elmora

Primary Registration District No. 2020

File No. 8358

City of Hammett

(No. ....., ... St.)

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances M. Hyland

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Nov (Month) 28 (Day) 1858 (Year)

7. AGE

55 yrs. 7 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John Hyland

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Maryann Pye

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. F Taylor.

(Address) Hammett.

15.

Filed July 24th 1914 B. O. Mather Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulminary hemorage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Eaton M. D.

7/24, 1914 (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? Not Known

Former or ~~usual~~ residence: Intermountain, Idaho.

19. ~~PLACE OF BURIAL OR~~ REMOVAL | DATE OF BURIAL

Moulton Home July 24 1914

20. UNDERTAKER | ADDRESS

J. M. Owen Kimhowa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 134
County of Elmore
Primary Registration District No. 2020
City of South Boise River (No. ..... St.)
File No. 8359
Registered No. 20
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Champ Ramsey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January (Month) 28 (Day) 1866 (Year)

7. AGE: 48 yrs. 4 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Madison Ramsey Sr

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Maryann Mackley

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Madison Ramsey Jr
(Address) Bruneau Idaho

15. Filed July 18th 1914 B.O. Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
accidental drowning
in South Boise River
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ? yrs. ..... mos. ..... ds.
(Signed) W. L. Easton M. D.
7/18 1914 (Address) Coroner Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho | DATE OF BURIAL: July 18 1914

20. UNDERTAKER: J M Cowen | ADDRESS: Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 8360
Registered No. 33

1. PLACE OF DEATH.
County of Cassia
City of Burley (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Faris Bunn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Single

6. DATE OF BIRTH: July (Month) 8th (Day) 1914. (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work — — — — —
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Burley, Idaho.

10. NAME OF FATHER W. J. Bunn

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Ellis Sanford.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Bunn
(Address) Burley, Idaho

15. Filed 7-11-14 191... Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1914, to July 11 1914, that I last saw him alive on July 11 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
7-8 1914 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley, Ida.	7-11-14 191...
20. UNDERTAKER: None.	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of

Registration District No. 3

Primary Registration District No. 2017

(No. ..... , ... St.)

File No. 42

Registered No. 826

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Lowell Ferguson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. May (Month) 2 (Day) 1896 (Year)

7. AGE: 18 Yrs. 2 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canyon Co Ida

10. NAME OF FATHER: Chas Ferguson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Josephine Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): John Nelson
(Address): Parma Ida

15. Filed July 8 1917 — Ludwig Aldrich, Local Registrar

SVMS - YORK CO., FORMS 4 SHEETS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to July 8, 1914, that I last saw h in alive on July 8 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
General tuberculus infection

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R Clemens M. D.
7/9 1914 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma — DATE OF BURIAL: July 9 1917

20. UNDERTAKER: Platt Peckham case — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2007

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4-15

Registered No. 18363

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

City or County of Parma

City of .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herschel Hale Clore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH. ~~July~~ Oct 16 (Month) ~~20~~ (Day) 1893 ~~1914~~ (Year)

7. AGE: 20 Yrs. 9 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER William S. Clore

11. BIRTHPLACE OF FATHER (State or Country) Ky

12. MAIDEN NAME OF MOTHER Lilla Haggard

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William S. Clore
(Address) Parma Idaho

15.
Filed Aug 8 1917
Lulu Waldron
Local Registrar

SYMS - YORK CO., PHS. & SONS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1914, to July 20 1914, that I last saw h[illegible]ive on 7/20 1914, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. F. Clemens M. D.
7/21 1914 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma — DATE OF BURIAL: July 22 1914

20. UNDERTAKER: Platt Peckham Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2007
File No. 45
Registered No. 8264

1. PLACE OF DEATH.
County of Canyon
City of Parma
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hannah Steel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH. Oct (Month) 29 (Day) 1847 (Year)

7. AGE: 66 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Ored Pearson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Steel
(Address) Parma Ida

15.
Filed Aug 8 1914 Lucie Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 1914, to July 22 1914,
that I last saw h..... alive on July 20 1914,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Typhoid fever
about
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Dilirium Tremens
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Hillman Waldron M. D.
19..... (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Omaha Neb — DATE OF BURIAL: July 25 1914

20. UNDERTAKER: Peckham Bros Co — ADDRESS: Parma

SYMS - YORK CO., PTG. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8365

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nyland G Mc Clellan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 13 (Day) 1913 (Year)

7. AGE: 1 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: A W Mc Clellan

11. BIRTHPLACE OF FATHER (State or Country): Arizona

12. MAIDEN NAME OF MOTHER: Geneva Porter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A W McClellan

(Address) Rupert Idaho

15.

Filed ..... 191....

O H Scott
Local Registrar

STATE - YORK CO., PTRS. & BOOK. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1914, to July 3 1914, that I last saw him alive on July 3 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Simons M. D.

7-6 1914 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: ..... 191....

20. UNDERTAKER: W. G. Goodmen — ADDRESS: Rupert

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 8366
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka
City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert N Banta

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 17 (Day) 1900 (Year)

7. AGE 9 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER H H Banta

11. BIRTHPLACE OF FATHER (State or Country) Neb

12. MAIDEN NAME OF MOTHER N.M Banta

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Myrtle Craig

(Address) Rupert

15.

Filed ..... 191....

O H Scott
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1914, to July 1 1914, that I last saw him alive on July 1 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) C. P. Sprague, M. D.

7-6 1914 (Address) Rupert, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery

DATE OF BURIAL July 2 1914

20. UNDERTAKER W.G. Goodmen

ADDRESS Rupert

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8367

Registered No. .....

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie L. Banta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 5 (Day) 1911 (Year)

7. AGE 3 Yrs. ..... Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER H. H. Banta

11. BIRTHPLACE OF FATHER (State or Country) Ark

12. MAIDEN NAME OF MOTHER N. M.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Myrtle Craig

(Address) Rupert

15. Filed July 5 1914

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1914, to July 4 1914, that I last saw h-- alive on July 3 1914, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

7-6 1914 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery — DATE OF BURIAL July 4 1914

20. UNDERTAKER W. G. Goodenough — ADDRESS Rupert

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8368

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret C. Banta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 28 (Day) 1908 (Year)

7. AGE 6 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER H H Banta

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER N. M.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Myrtle Craig

(Address) Rupert Idaho

15. Filed July 2 1914

O. L. Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1914, to July 1 1914, that I last saw h-21 alive on July 1 1914, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever.

.....

.....

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) 2 wks. .....mos.....ds.

(Signed) C. L. Moore M. D.

7-6 1914 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery

DATE OF BURIAL July 2 1914

20. UNDERTAKER W. G. Goodman

ADDRESS Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 3199
File No. I 8369
Registered No. 15

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edmond A. Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. 13 (Month) th (Day) 1899 (Year)

7. AGE: 13 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Joseph H. Taylor

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edith Fairchilds

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Birks
(Address) Oakley

15. Filed May 10 1914 E. P. Holmes Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1914, to July 18th 1914, that I last saw h[illegible] alive on July 18th 1914, and that death occured on the date stated above, at 4.50 P.M.

The CAUSE OF DEATH* was as follows:
Articular Rheumatism
Myocarditis ? Endocarditis
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Acute dilatation of Stomach
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. R. Nelson M. D.
7/5 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley — DATE OF BURIAL: 7-19 1914

20. UNDERTAKER: J. A. Ellison — ADDRESS: Oakley

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. U 8370

Registered No. 14

1. PLACE OF DEATH.

County of Cassia

City of Marion

Registration District No. 170

Primary Registration District No. 199

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Max Snowball

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July 13 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 3½ ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Bud Snowball

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Clara Marlin

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. P. Oldham
(Address) Oakley

15. Filed 8/10 1914 E. P. Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1914, to July 16 1914, that I last saw h alive on July 16 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pertussis Convulsions.

(Duration) ..... yrs. ..... mos. 1½ ds.

Contributory (Secondary) Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. P. Oldham M. D.

7/17 1914 (Address) Oakley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Marion — DATE OF BURIAL: 7/17 1914

20. UNDERTAKER: H. W. Sessions — ADDRESS: Marion

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

Primary Registration District No. 1011

File No. 8379

Registered No. 244

County of Latah

City of Moscow (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H. Crowley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 3 (Day) 1877 (Year)

7. AGE: 36 yrs. 6 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Crowley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Florence Viola Crowe

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Crowley.
(Address) Bremerton Wash. R6-5

15. Filed July 20 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at not known M.

The CAUSE OF DEATH* was as follows:
accendent by falling out of auto

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. McCarter coroner M. D.

19.... (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: July 20 1914

20. UNDERTAKER: Leo Seltz — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. Sisters Hospital St.)

File No. 8373
Registered No. 43
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Daniels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
January (Month) 3 (Day) 1839 (Year)

7. AGE
75 yrs. 1 mos. [illegible] ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Daniel G. Daniels

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert F. Daniels
(Address) Moscow Idaho

15.
Filed July 23 1914 J. F. Ras
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1914, to July 22 1914, that I last saw h/ im alive on July 21 1914, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
acute septic cholangitis

(Duration) yrs. mos. 13 ds.
Contributory (Secondary) General Debility
(Duration) yrs. mos. ds.

(Signed) Joseph Caspary M. D.
July 23 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Moscow
DATE OF BURIAL 7/24 1914

20. UNDERTAKER G A Stotz
ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2138
File No. 8375
Registered No. 11

1. PLACE OF DEATH.
County of Blaine
City of Soldier (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Little
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 3 (Month) (Day) 1850 (Year)

7. AGE: 64 yrs. 4 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Va.

10. NAME OF FATHER: Marcus Boyd

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Serinda Price

13. BIRTHPLACE OF MOTHER (State or Country): Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel M. Pinneau
(Address) Soldier Idaho

15. Filed July 7 1914 D A Higgs Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1914., to July 6 1914 that I last saw her alive on July 6 1914, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Valvular lesion
(Duration) 1 yrs. 2 mos. 2 ds.
(Signed) D A Higgs M. D.
July 7 1914 (Address) Soldier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soldier — DATE OF BURIAL: July 8 1914

20. UNDERTAKER: Jig Morrill — ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2207
(No. ....., ... St.)

File No. 8376
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isabell Chapman.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: July (Month) 24 (Day) 1901 (Year)

7. AGE: 6 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: A. B. Chapman

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Clara Lucas

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Lucas
(Address) Harrison Ida

15.
Filed July 27 1914 K. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1914, to July 24 1914
that I last saw her alive on July 24 1914
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Sweeney M. D.
July 24 1914 (Address) Harrison Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Randell Minn.
DATE OF BURIAL ..... 191...

20. UNDERTAKER: E. W. Wheeler
ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SUNSET-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8377

Registered No. 18

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 126

Primary Registration District No. 2204

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Archer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 30 (Day) 1871 ~~868~~ (Year)

7. AGE 42 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Loggin Camps

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER John Archer

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Matilda

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hiram Archer

(Address) Harrison Ida

15. Filed July 8 1914 R S Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h— alive on ..... 191...,
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Gunshot wound
penetrating heart
Homicidal

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Rogers M. D.

..... 19..... (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL Waitsburg Wash — DATE OF BURIAL ..... 191...

20. UNDERTAKER E. W. Wheeler — ADDRESS Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

File No. 8278
Registered No. 99

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Norton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 1 (Day) 1857 (Year)

7. AGE: 54 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: James Callahan

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Sarah Cliff

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cathrus J. Norton
(Address) Harrison Ida.

15. Filed Aug 4 1914 — E. B. Jensen, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1913, to July 3 1914, that I last saw her alive on July 3 1914, and that death occured on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of breast

(Duration) 1 Yrs. 5 mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Reger M. D.
July 6 1914 (Address) Harrison

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida — DATE OF BURIAL: July 7 1914

20. UNDERTAKER: E. W. Wheeler — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8380

Registered No. .....

Registration District No. 32

Primary Registration District No. 2049

(No. .... St.)

1. PLACE OF DEATH.

County of Kootenai

City of St Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E W Lillard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 17 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer in Sawmill
(b) General nature of industry, business, or establishment in which employed (or employer): at Ells River, Ida

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Sam Lillard

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lillard
(Address) Ells River, Ida

15. Filed January 11 1914 M. F. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 9 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Jan 9 1914, that I last saw h Lillard alive on Jan 9 1914 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Appendicitis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Cornwall M. D.

1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries, Ida — DATE OF BURIAL: Jan 12 1914

20. UNDERTAKER: M. F. Mulcahy — ADDRESS: St Maries, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS—YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai — Registration District No. 32 — File No. 8382

City of St Maries — Primary Registration District No. 2049 — Registered No.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Craig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 50 Yrs. — Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Yard foreman for
(b) General nature of industry, business, or establishment in which employed (or employer): M. P. & P. R. Rd Avery Idaho

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jno. Mc Craig
(Address) Parkaff Avery, Idaho

15. Filed July 29 1914 W. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Jan 22 1914, that I last saw h[illegible] alive on Jan 22 1914, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) 5 yrs. mos. 10 ds.

Contributory (Secondary) Nephritis

(Duration) [illegible] yrs. mos. ds.

(Signed) H. B. Cornwall M. D.

19.... (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Maries, Idaho	Jan 24 1914
20. UNDERTAKER W. L. Mulcahy	ADDRESS St Maries, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 8384
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Fernwood
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick O'Brien

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 17 (Month) (Day) 1872 (Year)

7. AGE: 42 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Worked in Logging
(b) General nature of industry, business, or establishment in which employed (or employer)..... Camp.

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. Douglas
(Address) Fernwood, Idaho

15. Filed July 23 1914 W. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Back broken, by log
struck by a falling tree
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Shackelford Coroner M. D.
July 22 1914 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Edmonton, Alta Canada
DATE OF BURIAL ..... 191...

20. UNDERTAKER: W. L. Mulcahy
ADDRESS Fernwood

SYMS-YORK CO., PTRS. & BOOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8385
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A W E Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1839 (Year)

7. AGE
75 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gardener
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. E. Cleary
(Address) St Maries, Ida.

15.
Filed July 5 191 4 H L Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1914, to July 3 1914, that I last saw h..... alive on ..... 1914, and that death occured on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:
Diabetes
Cerebral hemorrhage

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O L Platt M. D.
July 5 1914 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries, Ida. DATE OF BURIAL: July 6 1914

20. UNDERTAKER: H L Mulcahy ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Pocono

Registration District No. 32

Primary Registration District No. 2049

(No. ..... , ... St.)

File No. 8386

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Truesdall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 23 (Day) 1894 (Year)

7. AGE: 20 Yrs. 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student, but at time of death was keeping time for Seattle Car Co

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: L. N. Truesdell

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Anna Mc Vannet

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. N. Truesdell

(Address) Seattle, Wash

15. Filed July 24 1914 · V. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hanging

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Lukas A. Schultz J.P. M. D.

July 23 1914 (Address) at Mines, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Seattle Wash. DATE OF BURIAL ..... 191.....

20. UNDERTAKER: V. L. Mulcahy ADDRESS Mines

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STNRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)
File No. 8287
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Marble Creek near
If death occurs away from usual residence, give facts called for under special information. Pocono

2. FULL NAME F. A Govier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't Know

6. DATE OF BIRTH. (Month) V (Day) — (Year) 1

7. AGE: about 50 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: worked on logging chute
(b) General nature of industry, business, or establishment in which employed (or employer): saw woods / Laborer

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Paul Hans
(Address) .....

15. Filed July 30 1914 H. L. McCauley Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Struck by log while working on logging chute
Body all broken up
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.
(Signed) Chas. R. Schultz M. D.
July 19 14 (Address) Justice of the Peace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho
DATE OF BURIAL: July 31 1914

20. UNDERTAKER: H. L. McCauley
ADDRESS: St Maries Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St. Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 8283
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Randall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH
March (Month) 21 (Day) 1868 (Year)

7. AGE
46 yrs. 4 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Engineer (stationary)
(b) General nature of industry business, or dstablishment in which employed (or employer) Unloading logs

9. BIRTHPLACE (State or Country) Lycoming Co. Pennsylvania

10. NAME OF FATHER Jessie Randall

11. BIRTHPLACE OF FATHER (State or Country) New York State

12. MAIDEN NAME OF MOTHER Mary Teters.

13. BIRTHPLACE OF MOTHER (State or Country) New York State.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Frank Randall
(Address) St Maries Ida

15.
Filed July 9 1914 H. Le Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidentally thrown from a logging unloading car loaded w/ logs. Internal Injuries
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. B. Wood Coroner M. D.
July 9 1914 (Address) Coeur D'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Maries	July 9 1914
20. UNDERTAKER	ADDRESS
H. Le Mulcahy	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8390
Registered No. 7

1. PLACE OF DEATH.
County of Latah
City of Genesee

Registration District No. 62
Primary Registration District No. 214
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed - Dye

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 21 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 3 min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Genesee
10. NAME OF FATHER: J. N. Dye
11. BIRTHPLACE OF FATHER (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: L. Schooler
13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James W. Dye
(Address) Genesee

15. Filed July 22 1914 W. H. Chase Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1914 to July 21 1914
that I last saw h[illegible] alive on July 21 1914
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cyanosis Neonatorum

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature Birth
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Chase M. D.
July 22 1914 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: 7-22 1914

20. UNDERTAKER: J. N. Dye ADDRESS: Genesee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Teton
City of Genesee

Registration District No. 6
Primary Registration District No. 2142
(No. ....., ... St.)

File No. 8391
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed - Dye

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 21 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Genesee

10. NAME OF FATHER: J. H. Dye

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Emma Schaeler

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James H Dye
(Address) Genesee

15. Filed July 22 1914 C. N. McKeen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1914, to July 22 1914
that I last saw her alive on July 21 1914
and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Stillborn - due to premature birth (7 mos)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. N. McKeen M. D.

July 22 1914 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: L. D. F.
DATE OF BURIAL: July 22 1914

20. UNDERTAKER: J. H. Dye
ADDRESS: Genesee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 57
County of Bear Lake Primary Registration District No. 2136
City of Montpelier (No. ....., ... St.)
File No. 8392
Registered No. *

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vivian Cook

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 2nd (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montpelier

10. NAME OF FATHER: Clifford Cook

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Armintа Wilcox

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clifford Cook
(Address) Montpelier

15. Filed 8/2/1914 H H Hug Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1914, to Aug 2 1914 that I last saw h[illegible] alive on Aug 2 1914 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Atelectasis of Lungs
Immediate Cause of Death
Not Known
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jas F Cuthey M. D.
Aug 2 1914 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State Three yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence: Montpelier Ida

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida
DATE OF BURIAL: 8/3/1914

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 8393
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Phillips
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Not Known (Month) 1 (Day) (Year)

7. AGE about 30 years. Yrs. Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer on Bridge
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER T. J. Phillips

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE REST OF MY KNOWLEDGE.
(Informant) P. C. Vincent
(Address) Montpelier

15. Filed 7/27/1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 26th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental death Fell from moving train 3 miles west of Montpelier Idaho
(Duration) ..... Yrs. ..... mos. — ds.
Contributory (Secondary) —
(Duration — yrs. — mos. — ds.
(Signed) [illegible]
7/27 1914 (Address) Montpelier Bear Lake Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Tupelo, Miss.

19. PLACE OF BURIAL OR REMOVAL Tupelo Miss. DATE OF BURIAL 7/31/1914

20. UNDERTAKER J. E. Wallace ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 52

County of Beaulake

Primary Registration District No. 2136

File No. 8304

City of Montpelier (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Randolph Eckloff

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 31 (Day) 1861 (Year)

7. AGE: 53 yrs. 11 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mine Operator
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Eckloff

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. L. Eckloff
(Address) Montpelier Idaho

15.
Filed 7/21 191X
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
7 (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 191..., to ——, 191..., that I last saw him alive on July 18 1914 and that death occurred on the date stated above, at 6.4 M.

The CAUSE OF DEATH* was as follows:
Perforating Ulcer of the Stomach

(Duration) dont Know yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) dont Know yrs. — mos. — ds.

(Signed) E. F. Kenyon M. D.
7/20 1914 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Washington, D C

19. PLACE OF BURIAL OR REMOVAL: Washington D. C. DATE OF BURIAL: July 24 1914

20. UNDERTAKER: O. A. Schumacher ADDRESS: Pocatello

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 8895
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martina Larsen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 16 1 (Month) (Day) (Year)

7. AGE: 49 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Peter Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Andrew Larsen
(Address): Montpelier Idaho

15. Filed 7/7/1914 H. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 5 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1914, to July 5 1914, that I last saw h[illegible] alive on July 4 1914, and that death occurred on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:
Uremic Poison

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Don Poyser M. D.
7/7/1914 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 10 yrs. ..... mos. ..... days. In the State 35 yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Denmark.

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho | DATE OF BURIAL: 7/7/1914

20. UNDERTAKER: None. | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 1976Q

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Whitebird
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 8226
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Kate E Canaan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: (Month) • (Day) 1884 (Year)

7. AGE: 29 yrs. mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Robert A Badley

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Kathrine Greer

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J C Canaan
(Address): Whitebird Ida

15.
Filed 191
W A Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1913, to Feb 18 1914, that I last saw her alive on Feb 17 1914, and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:
Sarcoma of Right ovary
operated
Removed by abdominal incision
(Duration) yrs. 6 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W A Foskett M. D.
Feb 28 1914 (Address) Whitebird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Whitebird
DATE OF BURIAL: Feb 19 1914

20. UNDERTAKER: Hancock
ADDRESS: Grangeville

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28397
Registered No. 6

1. PLACE OF DEATH.
County of Nez Perce
City of Gifford
Registration District No. 92
Primary Registration District No. 2170,
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilma Beryl Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: June (Month) 2 (Day) 1914 (Year)

7. AGE: x yrs. 1 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ward L. Smith

11. BIRTHPLACE OF FATHER (State or Country): W. Va

12. MAIDEN NAME OF MOTHER: Ollie Speer

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ward L.Smith
(Address) St.Maries Ida.

15.
Filed 7/18/1914.xxx
E E Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th 1914, to 7/17 /1914 that I last saw her alive on July 17 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Inanition (congenital)

..... (Duration) xxx yrs. 1 mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E.E. Watts M. D.

7/ 17 1914 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lookout Ida
DATE OF BURIAL: 7/19 1914

20. UNDERTAKER: W.E.Lame (acting)
ADDRESS: Lookout.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8988

Registered No.

1. PLACE OF DEATH.

Registration District No. 29

County of Bonneau

Primary Registration District No. 2156

City of Bonneau Ferry Ida (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret A. Eldeston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: January (Month) 25th (Day) 1839 (Year)

7. AGE: 75 yrs. 6 mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: John Boyer

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H L Medbery

(Address) Bonneau Ferry Ida

15.

Filed Aug. 3- 1914, E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1914, to Aug. 2- 1914, that I last saw h[illegible] alive on Aug. 1 - 1914 and that death occurred on the date stated above, at 2.30 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

8/2 1914 (Address) Bonneau Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonneau Ferry Ida

DATE OF BURIAL: 8 3 1914

20. UNDERTAKER: L J Moore

ADDRESS: Bonneau Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8399
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Potlatch Country (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Wilbram D. McGee.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: Feb. 2 1860 (Month) (Day) (Year)
7. AGE: 54 yrs. 5 mos. 3 ds. IF LESS than 1 day how many ... hrs. or ... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: John McGee
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray McGee
(Address) Palouse Wash
15. Filed July 6th 1914 D. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 5 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Did not see him alive 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Suicide - Pistol shot

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo T Boyd M. D.
July 6 1914 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ / DATE OF BURIAL
Palouse Cemetery July 7 1914
20. UNDERTAKER: E Anderson
ADDRESS: Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8100
Registered No.

1. PLACE OF DEATH.
County of Latah.
City of Potlatch
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145

2. FULL NAME Deword Slocum.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH: July (Month) 8 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clyde W. Slocum.

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Pearl Jacks.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde W Slocumm
(Address) Potlatch Idaho

15.
Filed July 18th 1914
D. Jr. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1914, to July 17th 1914
that I last saw him alive on July 17 1914
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Asthenia
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Jr. Thompson M. D.
July 18th 1914 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee. Idaho — DATE OF BURIAL: July 19 1914

20. UNDERTAKER: Parents. — ADDRESS: Potlatch

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

CERTIFICATE OF DEATH

1. [illegible] District No. 15

County of Latah, Primary Registration District No. 246

City of Potlatch (County Farm) No. [illegible] St.)

File No. 8401

Registered No.

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME Geo W Stewart

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar. (Month) 3 (Day) 1846. (Year)

7. AGE: 68 yrs. 3 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R L Smith
(Address) Palouse Wash

15.
Filed July 22nd 1914 D. W. Thowsee Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 20 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see, being alive. 191...
that I last saw h... alive on ... 191...
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Heart Failure
Dropped Dead no
cause apparent
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo Boyd M. D.
19... (Address) Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Garfield Wash
DATE OF BURIAL: July 22 1914

20. UNDERTAKER: Frank Grimm
ADDRESS: Garfield Wn

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No. 2077
(No. ..... St.)

File No. 8402
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nolen Clarence Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, (MARRIED), WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 4 (Day) 1887 (Year)

7. AGE: 37 Yrs. 5 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Marion Carter

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Louisa Mott.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Bessie Carter
(Address) .....

15. Filed July 4 1914
J. Mumpley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to July 4 1914, that I last saw him alive on July 2 1914, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration Hemorrhage Yrs. ..... mos. ..... ds.
(Signed) J. Mumpley M. D.
7-3 1914 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: 7-6 1914

20. UNDERTAKER: W. B. Evans. — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS-WOOD CO., PTGS. & PUBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 8103
Registered No. ____

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane R. Andrew

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. June (Month) 18th (Day) 1838 (Year)
7. AGE: 76 Yrs. — Mos. 17 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None
9. BIRTHPLACE (State or Country): Greensburg Indiana USA
10. NAME OF FATHER: Richard Braden
11. BIRTHPLACE OF FATHER (State or Country): Kentucky USA
12. MAIDEN NAME OF MOTHER: Nancy Donnell
13. BIRTHPLACE OF MOTHER (State or Country): Indiana USA
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. I. F. Constant
(Address) Buhl Idaho
15. Filed July 6 1914 — J. H. Merrifield, Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 7 1914, to July 5 1914, that I last saw h.er alive on July 5th 1914, and that death occured on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Carcinoma Rectum
about one year
(Duration) { judging from history Yrs. mos. ds.
Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) C. F. McClung M. D.
7/5 1914 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? Buhl Idaho
Former or usual residence Buhl Idaho

19. PLACE OF BURIAL OR REMOVAL: Spencer Iowa — DATE OF BURIAL ____ 1914
20. UNDERTAKER: H B Evans — ADDRESS ____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of Buhl.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39

Primary Registration District No. 7087

(No. ....., ... St.)

File No. 8404

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Howe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Single

6. DATE OF BIRTH

7 (Month) 8 (Day) 1914 (Year)

7. AGE

✓ yrs. ✓ mos. ✓ ds.

IF LESS than 1 day how many 7 hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) 307 W. Buhl.

10. NAME OF FATHER C. P. Stewart.

11. BIRTHPLACE OF FATHER (State or Country) Wash.

12. MAIDEN NAME OF MOTHER Hettie Gleason.

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. N. Mumpley

(Address) Buhl Ida.

15.

Filed 7-9 1914 J. N. Mumpley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

7 (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-8 1914, to 7-8- 1914, that I last saw her alive on 7-8 1914, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Mumpley M. D.

7-8 1914 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
At Home	7-9 1914
20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 7087
File No. 8405
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Burke
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Elsie Wade

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W	Single

6. DATE OF BIRTH. Jan (Month) 21 (Day) 1914 (Year)

7. AGE ....X.... Yrs. ....6.... Mos. ....8.... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burke Idaho

10. NAME OF FATHER George Wade

11. BIRTHPLACE OF FATHER (State or Country) New Jersey

12. MAIDEN NAME OF MOTHER Nellie Zimmerman

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Wade
(Address) .....

15. Filed 7-30 1914 J. A. Murphy Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-27 1914, to 7-29 1914, that I last saw her alive on 7-28 1914, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum
.....
.....
(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Murphy M. D.
7-29 1914 (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burke Ida — DATE OF BURIAL July 30 1914

20. UNDERTAKER H B Evans — ADDRESS Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 8402
Registered No. 20

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Delos E. Sims

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1880 (Year)

7. AGE: 34 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: William H. Sims

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Elizabeth Brownell

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E. L. Davis
(Address): Aberdeen

15.
Filed July 17 1914 McNaughton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1914, to July 16 1914, that I last saw h[illegible] alive on July 16 1914, and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Injuries to chest & lungs inflicted by an enraged bull.

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) —
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) McNaughton M. D.
July 17 1914 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Memorial Cemetery Aberdeen
DATE OF BURIAL: July 18 1914

20. UNDERTAKER: Acting E. L. Davis
ADDRESS: Aberdeen Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 79
County of Bonner
Primary Registration District No. 2156
City of Bonners Ferry Ida. No. ..... St.)
File No. 8407
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME A. Lee Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
50 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Lumber grader
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden.

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) (Rumor)
(Address) .....

15.
Filed 7/17/14 1914 E. E. Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 17th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture of skull -
(accidental - Struck by train)
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Fry, M. D.
7/17 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: 7/20 1914

20. UNDERTAKER: J. T. Moore ADDRESS: Bonners Ferry Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1 2 3

Primary Registration District No. 2 2 0 1

File No. 18 8108

County of Shoshone

City of Kellogg (Wardner Hospital St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Perpich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	single

6. DATE OF BIRTH

Nov. (Month) 20 (Day) 1911 (Year)

7. AGE

2 yrs. 8 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) South Dakota

10. NAME OF FATHER John Perpich

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Eva Pavicich

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Perpich

(Address) Kellogg, Idaho

15.

Filed 7/10 1914 Geo D Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July (Month) 3 (Day) 1914. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1914, to July 3 1914, that I last saw h.r alive on July 3 1914, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro-Spinal Meningitis

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Alex D. McCracken M. D.

July 5 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho. DATE OF BURIAL: July 5 1914

20. UNDERTAKER: E. B. Thornhill ADDRESS: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No. 2701
File No. 17 8409
Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vicko Vlastelc (Wm. Wallace)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6. DATE OF BIRTH
Do not know (Month) 1 (Day) 1885 (Year)

7. AGE
29 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER Vicko Vlastelc

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Annie Klekovich

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Martinich
(Address) Kellogg, Ida.

15.
Filed July 18th 1914 Geo. S. Leoher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw h alive on 191 , and that death occurred on the date stated above, at A. M.

The CAUSE OF DEATH* was as follows:
Accident - Think neck was broken - Caught by train of cars in mine & died before I saw him
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo. Kennett M. D.
7/10 1914 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte, Montana
DATE OF BURIAL: 191

20. UNDERTAKER: Bruce G. Worstell
ADDRESS: Wallace, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No. 7201
(No. ....., ... St.)

File No. 16 8410
Registered No. .....

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME — — Jahnke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 6th 1914
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. 1/2 hr.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Kellogg

10. NAME OF FATHER: Harry A Jahnke

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Hazel Wright

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 7/9 1914 Geo S Lesher
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on July 6 1914,
and that death occured on the date stated above, at 9 9 M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Lindsay M. D.
7/6 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg
DATE OF BURIAL: July 7 1914

20. UNDERTAKER: Thornhill
ADDRESS: Kellogg

McCrackey

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15 8111

Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1201
Primary Registration District No. 1203

2. FULL NAME Baby Rozic

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: June (Month) 28 (Day) 1914 (Year)

7. AGE: ....yrs. ....mos. ....ds.
IF LESS than 1 day how many ..1.... hrs. or ..15.. min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kellogg Idaho.

10. NAME OF FATHER: Victor Rozic

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mary Horick

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Victor Rozic
(Address): Kellogg, Ida.

15.
Filed 7/7/ 1914 Geo. S Lesher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1914, to June 28 1914
that I last saw him alive on June 28 1914,
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Premature delivery-underdeveloped.
Born at end of 6th month.
Lived about 1½ hours.

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary): Cause of premature delivery unknown.

(Duration) ....yrs. ....mos. ....ds.

(Signed) Alexander D. McCrackin M. D.
June 29 1914 (Address) Kellogg, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Ida.
DATE OF BURIAL: June 29 1914

20. UNDERTAKER: E B Shanklin
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7 or 81
Primary Registration District No. 1 or 3 —
(No. 9 , St.)

File No. 14 8412
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virginia Wright Janke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1913 (Year)

7. AGE: yrs. 7 mos. 8 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Harry Janke

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Hazel Wright

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. L. Janke
(Address):

15. Filed July 7 1914 Geo. D Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1914., to July 6 1914, that I last saw h.r alive on July 6 1914, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Epidemic Cerebral Spinal Meningitis.

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. E. Lindsay M. D.
July 8 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho.
DATE OF BURIAL: July 7 1914

20. UNDERTAKER: E. B. Thornhill
ADDRESS: Kellogg Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BKRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Kellogg

Registration District No. 2230

Primary Registration District No. 2403

(No. ....., ... St.)

File No. 13 8113

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tony Tolk

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.

Oct. (Month) ..... (Day) 1912 (Year)

7. AGE

1 Yrs. 8 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Infant.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Tony Tolk.

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER — —

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. E. Lindsay M.D.

(Address) Kellogg Idaho.

15.

Filed 6/27 1914 G. D. Leeher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1914, to June 22 1914, that I last saw him alive on June 21st 1914, and that death occured on the date stated above, at 1 9 M.

The CAUSE OF DEATH* was as follows:

Acute substitral
suffocation

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. E. Lindsay M. D.

June 22 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho. DATE OF BURIAL: June 24 1914

20. UNDERTAKER: E. B. Shanklee ADDRESS: Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 8414
Registered No. 44
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen Fanny Pugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH: September 24 1858 (Month) (Day) (Year)
7. AGE: 56 yrs. 9 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: John L. Holbrook
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Elizabeth Wright
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Beattie
(Address) Salmon, Ida.
15. Filed July 11 1914 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 10th 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1st 1914, to July 10 1914 that I last saw her alive on July 8th 1914 and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cancer of Breast
(Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. C. Winfield M. D.
July 11 1914 (Address) Salmon Ida

(*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Salmon Idaho | DATE OF BURIAL: 7-11" 1914
20. UNDERTAKER: Wm C Tobbe | ADDRESS: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & ADRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116

File No. 8315
Registered No. 43
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Mead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWER OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: exact date not known (Month) (Day) 1836 (Year)

7. AGE: 78 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: County Patient
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Do not know.

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Do not know.

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Durand
(Address) Salmon Idaho.

15. Filed 7-12 1914 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July - 12" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1914, to July 5th 1914, that I last saw him alive on July 5th 1914 and that death occurred on the date stated above, at 7th P. M.

The CAUSE OF DEATH* was as follows:
Paralysis (Hemiplegia)
Senile
(Duration) 1 yrs. ..... mos. ..... ds.
Contributory (Secondary) Cystitis (Urinary)
(Duration) 7 yrs. ..... mos. 10 ds.

(Signed) C. P. Bratton M. D.
7/13 1914 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 7-13" 1914

20. UNDERTAKER: W. C. Dockle
ADDRESS: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of May
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 8116
Registered No. 46
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Hammond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Aug (Month) 2. (Day) 1854 (Year)

7. AGE
59 yrs. 10 mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Ranches
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Lothrop Hammond

11. BIRTHPLACE OF FATHER (State or Country) Vt.

12. MAIDEN NAME OF MOTHER Sarah Adams Craigue

13. BIRTHPLACE OF MOTHER (State or Country) Vt.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Horn
(Address) May Idaho

15.
Filed 7-21 1914 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 16 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1914, to May 15 1914
that I last saw h.im alive on May 15 1914
and that death occurred on the date stated above, at 10.10 A.M.

The CAUSE OF DEATH* was as follows:
Bright's disease

.....(Duration) 7 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Kelley M. D.
6-17 1914 (Address) Challis, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: May Idaho. DATE OF BURIAL: June 17 1914

20. UNDERTAKER: Friends ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 8417
Registered No. 47

1. PLACE OF DEATH.
County of Lemhi
City of Salmon (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert M Jackson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: October (Month) ..... (Day) 1873. (Year)

7. AGE: 40 yrs. 9 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Saloon keeper
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John A Jackson

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Vera Jackson
(Address) Salmon Idaho

15. Filed August 1 1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 30" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1914, to July 30 1914
that I last saw him alive on July 30 1914
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculous trouble of Lungs.
and fatal neph

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Whitwell M. D.
7-1 1914 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: Aug 1" 1914

20. UNDERTAKER: J. M. Thiebolt
ADDRESS: Salmon Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. R.R. Shops St.)
File No. 5[illegible]16
Registered No. 203

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John P. Madden

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Month + Exact date unknown (Month) (Day) 1855 (Year)

7. AGE: 59 yrs. mos. ds. Near as known. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Foreman Pipe Shop
(b) General nature of industry business, or establishment in which employed (or employer): R.R.

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: John Madden

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.B. Coats
(Address) Pocatello Ida.

15. Filed July 24, 1914 O.B. Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 23d (Month) (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Suicide by shooting

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O.B. Steely Coroner M. D.
July 24, 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 24 1914

20. UNDERTAKER: Crawford & Schumacher — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 5
Registered No. 202

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. R.R., Shops St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Joseph malone

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: november 20th 1861 (Month) (Day) (Year)

7. AGE: 52 yrs. 8 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Supt of O.S.L. Shops Pocatello Idaho
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Westernport allegany co maryland

10. NAME OF FATHER: John malony

11. BIRTHPLACE OF FATHER (State or Country): County Galway Ireland

12. MAIDEN NAME OF MOTHER: Julia McGuire

13. BIRTHPLACE OF MOTHER (State or Country): County Cork Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J malone
(Address) 302 So ave 21 Los angeles Cal

15. Filed July 24 1914 O J Geary Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 23d 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Murdered — Shot through head

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O J Geary M. D.
July 24 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 26 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: Pocatello

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. - 84
Primary Registration District No. 21 61
(No. 517, Pocatello, Johnson Ave.)

File No. 8421 3
Registered No. 200

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Ben Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. July (Month) 18 (Day) 1914 (Year)

7. AGE: .....Yrs. .....Mos. .....ds.
IF LESS than 1 day how many ...8... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Benj F. Brown

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Pearl Bennette

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ray Russell
(Address) Pocatello, Idaho

15. Filed July 19 1914 — H. H. Healy, Local Registrar

BYNS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1914, to July 18 1914, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Still-born,

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. M. Sprague M. D.

19..... (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: July 19 1914

20. UNDERTAKER: Wallace & Evans — ADDRESS: Pocatello Id

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5422

Registered No. 199

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 853, N. Harrison Ave.)

2. FULL NAME Jacob Jacobson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: Dec. (Month) 8 (Day) 1834 (Year)

7. AGE: 79 yrs. 7 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Molder
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Jacob Jacobson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elias Jacobsen
(Address) 653 No Harrison Ave Pocatello

15. Filed July 18 1914 — O B Steery, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23rd 1914, to July 17th 1914 that I last saw h im alive on July 15th 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Septic Ulcer

(Duration) yrs. 4 mos. 2 ds.

Contributory (Secondary) Mental instability

(Duration) 2 yrs. 4 mos. ds.

(Signed) H. A. Coates M. D.

July 18th 1914 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: July 20 1914

20. UNDERTAKER: Wallace & Wann — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. ....., ... St.)

Registration District No. 84
Primary Registration District No. 2161

File No. 8425
Registered No. 198

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Rule

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 25 (Day) 1841 (Year)

7. AGE: 73 yrs. 3 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Cornwall England

10. NAME OF FATHER: Henry Rule

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Rule
(Address) Pocatello

15. Filed July 17 1914 — O B Leeds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1913, to July 15 1914 that I last saw him alive on July 15 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

~~Tuberculosis Pulmonalis~~
Nephritis

(Duration) 1 yrs. 10 mos. ..... ds.

Contributory (Secondary): Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. A. M. Newton M. D.

July 15 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: July 17 1914

20. UNDERTAKER: Wallace & Adams — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. ....., ... St.)
File No. 5812
Registered No. 197

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Jansen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: ..... (Month) ..... 1 (Day) ..... (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed July 16 1914 O. P. Hardy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1913, to July 15 1914 that I last saw him alive on July 15 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myelogenous Leukemia

(Duration) 1 yrs. 4 mos. ..... ds.

Contributory (Secondary) .....

(Duration) 1 yrs. 4 mos. ..... ds.

(Signed) Dr A. M. Newton M. D.

July 15 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Brigham City Utah
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Wallace & Wann
ADDRESS: Pocatello Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 5 8125
Registered No. 196

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 6 N. Garfield St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Queen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: September 17 1857 (Month) (Day) (Year)

7. AGE: 56 yrs. 10 mos. 27 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoemaker
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montreal, Canada

10. NAME OF FATHER: Francis Queen

11. BIRTHPLACE OF FATHER (State or Country): Montreal Canada

12. MAIDEN NAME OF MOTHER: Hermaine McGee

13. BIRTHPLACE OF MOTHER (State or Country): — Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Leda C. Queen
(Address) Pocatello, Idaho

15. Filed July 15 1914 O B Stacy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 14 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1914, to July 14th 1914, that I last saw him alive on July 11th 1914 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 5 yrs. — mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) W. A. Wright M. D.
7/16 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 16 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: City

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 4th Ave.) File No. 5 8426
Registered No. 195

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Fred Jay Dolberg Jr.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH: May (Month) 3 (Day) 1914 (Year)

7. AGE: — yrs. 2 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Fred J. Dolberg Jr.

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Myrtle T. Wray

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred J. Dolberg
(Address) Pocatello Ida.

15. Filed July 14 1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1914, to July 13 1914 that I last saw h— alive on July 1914, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows: Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

July 13 1914 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary DATE OF BURIAL: July 14 1914

20. UNDERTAKER: Wallace & Wann ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 8 4
County of Bannock Primary Registration District No. 2 1 6 1
City of Pocatello (No. 352, W Clarson St.) File No. 5 8 1 2
Registered No. 1 9 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob S. Boorger

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 18 (Day) 1848 (Year)

7. AGE: 66 yrs. — mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John Boorger

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed June 30 1914 J. P. Avery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20" 1914, to June 29" 1914 that I last saw him alive on June 29" 1914, and that death occurred on the date stated above, at 8 a.m. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Oedema

(Duration) yrs. mos. 10 ds.
Contributory (Secondary) Nephritis + Arteriosclerosis
(Duration) 10 yrs. mos. ds.

(Signed) H. A. Castle M. D.
June 29" 1914 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery DATE OF BURIAL: June 30 1914

20. UNDERTAKER: Wallace & Wann ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Robuts m.D.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4819

Registered No. 193

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 417, South Arthur St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John A. Toombs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 9 1859 (Month) (Day) (Year)

7. AGE: 54 yrs. 8 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Conductor R.R.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wm. Toombs

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Anne Sheam

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pauline Toombs
(Address) Pocatello

15. Filed June 30 1914 O. F. Neely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1914, to June 29 1914, that I last saw h.m alive on June 29 1914, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
nephritis & prostatitis

(Duration) 2 yrs. - mos. - ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas Gilbert M. D.
6/30 1914 (Address) Pocatello.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary
DATE OF BURIAL: 191

20. UNDERTAKER: Wallace & Wann
ADDRESS: Pocatello Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 84
County of Bannock
Primary Registration District No. 2161
City of Soda Springs (No. ....., ... St.)
File No. 48429
Registered No. 192
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dominick Sapiano

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Italian	Single

6. DATE OF BIRTH ✓ 1 .....
(Month) (Day) (Year)

7. AGE ✓ .....yrs. .....mos. .....ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) R. R. Section

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 6-27- 1914 O B Sweeney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
About ..... 191....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191..., to .....191...,
that I last saw h.....alive on .....191...,
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Murdered
Probably June 20-21-1914
.....(Duration).....yrs.....mos.....ds.

Contributory (Secondary) .....
.....(Duration).....yrs.....mos.....ds.

(Signed) O B Sweeney Coroner M. D.
6-26- 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soda Springs — DATE OF BURIAL: June 24 1914

20. UNDERTAKER: Wallace & Warner — ADDRESS: Pocatello Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8430
Registered No. 10

1. PLACE OF DEATH.
County of Owyhee
City of Silver
Registration District No. 43
Primary Registration District No. 2120
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theresa May Kelly

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Jan (Month) 31st (Day) 1914 (Year)
7. AGE: ..... yrs. 5 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Murphy.
10. NAME OF FATHER: Patrick H. Kelly.
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Laura May
13. BIRTHPLACE OF MOTHER (State or Country): Nampa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laura May Kelly
(Address) Wilson Ida
15.
Filed July 26, 1914 H. N. Schuyler, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 25 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 19, 1914, to July 25, 1914 that I last saw her alive on July 25, 1914 and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Acute dysentery, and strangulation of bowels.
..... (Duration) ..... yrs. ..... mos. 11 ds.
Contributory (Secondary) Cholera infantum & extreme hot weather (Duration) — yrs. — mos. 4 ds.
(Signed) H. N. Schuyler M. D.
July 25, 1914 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilson Cemetary. DATE OF BURIAL: July 26th 1914
20. UNDERTAKER: John Grete ADDRESS: Silver City.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Arco
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139
(No. ..... St.)

File No. 16
Registered No. 8431
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charles Lucas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1867 (Year)

7. AGE: 47 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mgr Quary mine
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Scranton Penn

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Chas Lucas
(Address) Arco, Idaho

15.
Filed 7/4 1914 Ewing
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1914, to July 4 1914
that I last saw h- alive on July 4 1914
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ewing M. D.
7/4 1914 (Address) Arco Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho
DATE OF BURIAL: 7-7 1914

20. UNDERTAKER: J. C. Fall
ADDRESS: Arco, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Kelyde
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139

File No. 14833
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edwin Robert Hawley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: February (Month) 9 (Day) 1836 (Year)

7. AGE: 78 yrs. 4 mos. 21 ds.
IF LESS than 1 day how many hrs. or min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman & Rancher
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Chautauqua Co. New York

10. NAME OF FATHER: Manley Hawley

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Amanda Berry

13. BIRTHPLACE OF MOTHER (State or Country): New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edith A Hawley
(Address) Kelyde Idaho

15.
Filed 6/30 1914 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-24 1914, to 6-30 1914
that I last saw h... alive on 6-28 1914,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH was as follows:
Acute Brights disease

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Senile Debility
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edith A Hawley M. D.
6/30 1914 (Address) Kelyde Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Idaho Falls Ida. DATE OF BURIAL: July 3 1914
20. UNDERTAKER: Joe Morley ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 105
County of Idaho Primary Registration District No. 2103
City of Cottonwood (No. ..... St.)
File No. 15 8434
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Edward Charles Egan
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: March (Month) 15 (Day) 1914 (Year)
7. AGE: ..... yrs. 4 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Pennsylvania
10. NAME OF FATHER: Edward Charles Egan
11. BIRTHPLACE OF FATHER (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Jane Hopkins
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Charles Egan
(Address) Cottonwood
15.
Filed July 28th 1914 W. Moore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 28, 11 AM 1914, to July 28, 3 PM 1914 that I last saw h sm alive on July 28 3 PM 1914, and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (Duration) — yrs. — mos. 7 ds.
Contributory (Secondary) —
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wesley F. Orr M. D.
July 29 1914 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida. DATE OF BURIAL: July 29 1914
20. UNDERTAKER: Harrison West ADDRESS: Cottonwood Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

YMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Ferdinand
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

File No. 14 8135
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Nancy Lindsay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Not Known (Month) 1 (Day) (Year)

7. AGE: 80 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Matthew

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not know

13. BIRTHPLACE OF MOTHER (State or Country): not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Frank
(Address) Ferdinand Idaho

15.
Filed July 13 1914 H B Burke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated death of deceased ~~1914~~, to ~~1914~~ ~~that I last saw h..... alive~~ on July 13 1914, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Cause unknown (natural)

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Senile debility.
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H B Burke M. D.
July 13 1914 (Address) Coroner Idaho County Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferdinand Idaho | DATE OF BURIAL: July 13 1914
20. UNDERTAKER: Henry W West | ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Priest River
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2158
(No. ..... St.)

File No. 8436
Registered No. [redacted] 8
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Alberta Matilda Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	married

6. DATE OF BIRTH
January 19 (Month) (Day) 1869 (Year)

7. AGE
45 yrs. 6 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business or establishment in which employed (or employer) ..... home on farm

9. BIRTHPLACE (State or Country) County of Brant, Canada

10. NAME OF FATHER John Thompson

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Dorothy Matilda Bull

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Moore
(Address) Priest River, Ida.

15.
Filed July 24 1914 E D McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1914, to July 24 1914, that I last saw her alive on July 23 1914, and that death occurred on the date stated above, at 5:00 PM.

The CAUSE OF DEATH* was as follows:

Mercuric Chloride poisoning

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E Denton McCarty M. D.
July 24 1914 (Address) E D McCarty Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River
DATE OF BURIAL: July 26 1914

20. UNDERTAKER: None
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Ahsahka (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
File No. 8138
Registered No. 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Titus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, ~~WIDOWED~~ OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 14 (Day) 1893 (Year)

7. AGE: 21 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home work
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Daley

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Titus
(Address) Ahsahka Ida

15. Filed July 1 1914 J. M. Tandy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1914, to July 1 1914
that I last saw h[illegible] alive on July 1 1914
and that death occurred on the date stated above, at [illegible] P.M.

The CAUSE OF DEATH* was as follows:
Uraemic Convulsion
.....
.....
..... (Duration) ..... yrs. 1 mos. ..... ds.
Contributory —
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tandy M. D.
July 1 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: July 3 1914

20. UNDERTAKER: W. C. Stoddard — ADDRESS: Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Fraun
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ; St.)

File No. 8139
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dwight Snyder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 4 (Month) (Day) 1914 (Year)

7. AGE: yrs. mos. 3 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wilps Idaho.

10. NAME OF FATHER: Blaine Snyder

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Hazel Cochran

13. BIRTHPLACE OF MOTHER (State or Country): West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Norswell
(Address) Orofino Ida

15. Filed Aug 1 1914 J. M. Faris Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1914 to July 7 1914
that I last saw her alive on July 7 1914
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Dysentery Intestinal Fever

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E M Norswell M. D.
July 7 1914 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
Fraun Ida July 8 1914

20. UNDERTAKER | ADDRESS
E E Stoddard | Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ..... St.)

File No. 8440
Registered No. 36
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Shea

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
1860 (Month) 1 (Day) (Year)

7. AGE
54 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Snowden
(Address) Moscow Ida

15. Filed Aug 1 1914 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 9th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19th 1912, to July 9, 1914, that I last saw h[illegible] alive on July 8, 1914, and that death occurred on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:
General Paresis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Johnulsmens M. D.
July 9 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Ida	7/11 1914

20. UNDERTAKER	ADDRESS
V. C. Stoddard	Gifford, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 8411
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seth Kelley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1859 (Year)

7. AGE: 55 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ills

10. NAME OF FATHER: Kelley

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S M Kelley
(Address) Greer Idaho

15. Filed Aug 1 1914 J. W. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914 to July 14 1914, that I last saw h.... alive on July 13 1914, and that death occurred on the date stated above, at 6 30 A.M.

The CAUSE OF DEATH* was as follows:
Gunshot wound of Chest.
.....
.....
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Cancer of stomach - Arterio sclerosis & Uraemia.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle W Horsner M. D.
July 14 1914 (Address) Oro Fino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greer Ida	July 15 1914
20. UNDERTAKER	ADDRESS
W C Stoddard	Gifford Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 7168
File No. 8119
Registered No. 38

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Floyd Wales
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 29 (Day) 1914 (Year)

7. AGE: 22 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Evans
(Address) Orofino, Idaho

15. Filed Aug 6 1914 J. M. Tracy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 23 1914, to July 29 1914, that I last saw h[illegible] alive on July 28 1914, and that death occurred on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:
Melancholia

(Duration) 4 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John Evans M. D.
July 31 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Bonner Co. Idaho

19. PLACE OF BURIAL OR REMOVAL: Bonner Ferry Ida
DATE OF BURIAL: 7 1914

20. UNDERTAKER: W C Stoddard
ADDRESS: Gifford Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Gilbert
(No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168

File No. 8412
Registered No. 39
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Hannah M. Khan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: July (Month) 17 (Day) 1841 (Year)

7. AGE: 73 yrs. ... mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: D. Luking

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lelain

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Khan
(Address) Gilbert, Idaho

15. Filed July 31 1914 J. M. Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to July 31 1914, that I last saw h... alive on July 31 1914, and that death occurred on the date stated above, at 3½ ... M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 2 yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. M. Finley M. D.
July 31 1914 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gilbert, Ida — DATE OF BURIAL: Aug 1 1914

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Gifford Ida

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 8414
Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME — — Tomlin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 24 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grangeville Ida

10. NAME OF FATHER: John F. Tomlin

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Maud Page

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John F Tomlin
(Address): Grangeville Ida

15. Filed Aug 6 1914 GB Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1914, to July 9 1914, that I last saw her alive on July 2 1914, and that death occurred on the date stated above, at 23 M.

The CAUSE OF DEATH* was as follows:
Congenital Patent Foramen Ovale in heart

(Duration) — yrs. — mos. 15 ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. 15 ds.

(Signed) C. W. Slusser M. D.
July 10 1914 (Address) Grangeville Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: July 10 1914

20. UNDERTAKER: W E Graham — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 8445
Registered No. 27

1. PLACE OF DEATH.
County of Idaho
City of Grunbruck (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jos Linton Baerlocher
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1835 (Year)

7. AGE: 79 yrs. 8 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Jos Ant Baerlocher

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elta Nef

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev J J M Baerlocher
(Address) Green Creek

15.
Filed aug 6 191 8 E S Stretton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Died Suddenly

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) No physician Called, M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green Creek — DATE OF BURIAL: July 7 1914

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

RESERVED FOR BINDING MARGIN

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of 40 from Shelley (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194

File No. 8417
Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Brigham McElveen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dont Know
(Month) (Day) (Year)

7. AGE: 63 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E J Peck Coroner.
(Address) Blackfoot Idaho

15. Filed June 20 1916 M E Parke
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Investigated death 191..., to ..... 191...,
~~that I last saw h alive on~~ 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gun Shot Wound-
Head- Cerebrum

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) M. E. Parke

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. E. Parke M. D.
19... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida
DATE OF BURIAL: June 20 1914

20. UNDERTAKER: E J Peck
ADDRESS: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8448
Registered No. 41

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1007
(No. 333, North Elmer St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Geneva L. Esterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January (Month) 29 (Day) 1914 (Year)

7. AGE: — yrs. 5 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): Infant

9. BIRTHPLACE (State or Country): Blackfoot Ida

10. NAME OF FATHER: John Esterson

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Flossa Messenger

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Davis M D
(Address) Blackfoot Ida

15. Filed July 25 1914 — M. E. Patrick, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1914, to July 25 1914
that I last saw her alive on July 25 1914
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis

(Duration) — yrs. — mos. 6 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Davis M. D.
7-25 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida — DATE OF BURIAL: 7-26 1914

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8449

Registered No. 11 1

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. , Mat Bonney St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Bertha Clapp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January 2 1876 (Month) (Day) (Year)

7. AGE: 38 yrs. 6 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: George J. Richardson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Ann Berry

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B Dawson MD
(Address)

15. Filed July 27 1914 M. E. Ritchie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 26 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1914, to July 26 1914
that I last saw her alive on July 26 1914
and that death occurred on the date stated above, at 1.45a M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) B Dawson M. D.

19 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida
DATE OF BURIAL: 7-27 1914

20. UNDERTAKER: E F Peck
ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

County of Bingham

Primary Registration District No. 1007

City of Blackfoot (No. 285, East Judicial St.)

File No. 850

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Leschofski

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: April 4 1862 (Month) (Day) (Year)

7. AGE: 52 yrs. 3 mos. 20 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): (Locksmith)

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Otto Leschofski

11. BIRTHPLACE OF FATHER (State or Country): Bohemia

12. MAIDEN NAME OF MOTHER: Sophia Saroski

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Leschofski
(Address) Tabor, Idaho

15. Filed July 27 1914 W. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1914, to July 26 1914, that I last saw him alive on July 26 1914 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Multiple injury to chest Lungs & ribs from kick of horse & run over with wagon
(Duration) ..... yrs. ..... mos. 2 ds.
Contributory Pneumonia
(Secondary)
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) W. E. Patrick M. D.
7-27 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort City Cem. Blackfoot — DATE OF BURIAL: July 28 1914

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 8451
Registered No. 113

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. 170 N. Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas S. Dibble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October 31 (Month) (Day) 1877 (Year)

7. AGE 41 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Garage owner & Mgr.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Joseph Dibble

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Josie Dibble

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Laura E Dibble
(Address) Pocatello Ida.

15. Filed July 31 1914 M. C. Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1914, to July 28 1914, that I last saw h alive on July 28 1914, and that death occured on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:

General Peritonitis
after operation.
(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) appendicitis
(Duration .....yrs.....mos. 5 ds.

(Signed) H. J. Sommercorn M. D.
7/31 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview Cemetery — DATE OF BURIAL: July 31 1914
20. UNDERTAKER: E J Buck — ADDRESS: Blackfoot Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Caldwell (No. 2, St.)
File No. 8452
Registered No. 39
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lee Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ~~Sept~~ Oct 24th (Month) (Day) 1881 (Year)

7. AGE: 22 yrs. 9 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash Iowa

10. NAME OF FATHER: A.T. Rogers

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary Bell Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C B Lewis
(Address) Caldwell Ida

15.
Filed 7-10-1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~191~~, to ~~191~~ that ~~I last saw him~~ alive on ~~191~~, ~~and that~~ death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Suicide
Gun shot wound

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F.T. Robinson Coroner M.D.
7/6/1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: July 10 1914

20. UNDERTAKER: Jones Fur Co. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 9158
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A E Hoover

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May 30th (Month) 1 (Day) 1846 (Year)

7. AGE: 68 yrs. 1 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: David Hoover

11. BIRTHPLACE OF FATHER (State or Country): dont know

12. MAIDEN NAME OF MOTHER: Cathrin Young.

13. BIRTHPLACE OF MOTHER (State or Country): dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida Frost Norman.
(Address) Caldwell Idaho.

15.
Filed 7-12- 1914 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1914, to July 10. 1914
that I last saw h/m alive on July 10 1914,
and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia on Feb. 1914
Bright's Disease
(Duration) about yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. D. Foster M. D.
July 12 1914 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 7-12 1914

20. UNDERTAKER: W. E. Dyer
ADDRESS: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

File No. 8454

County of Canyon

City of Caldwell, (No. ....., ... St.)

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob W. Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1879 (Year)

7. AGE: 34 yrs. 9 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fulton Co. Ill.

10. NAME OF FATHER: R. M. Evans

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: L. R. Cannin

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ralph Evans
(Address): Caldwell Ida

15. Filed July 13 1914 — Jas. L. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to July 12 1914, that I last saw h[e] alive on July 7 1914 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

July 13 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Church of the Brethren, Boise Valley — DATE OF BURIAL: July 13 1914

20. UNDERTAKER: B. F. Leavell — ADDRESS: Parma R. 4, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8155

Registered No. 42

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Caldwell. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2005

2. FULL NAME William L. Davis.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: June 25th (Month) (Day) 1832 (Year)

7. AGE: 82 yrs. — mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Teacher
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Apollo Penn.

10. NAME OF FATHER: Wm Davis.

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm W. Davis
(Address) Caldwell R-3-B180

15.
Filed July 15th 1914 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1914, to July 13 1914, that I last saw him alive on July 13 1914, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis
..... (Duration) Short Time yrs. mos. ds.
Contributory (Secondary) .....
..... (Duration) yrs. mos. ds.

(Signed) J. E. Cole M. D.
July 14 1914 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge
DATE OF BURIAL: July 15 1914

20. UNDERTAKER: W. E. Dyer
ADDRESS: Caldwell. Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8456

Registered No. 43

1. PLACE OF DEATH.

County of Canyon

City of Caldwell (No. ....., ... St.)

Registration District No. 3

Primary Registration District No. 1005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary Jane Potts

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: August (Month) 5 (Day) 18 38 (Year)

7. AGE: 75 yrs. 11 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: house Keeping
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nashvill Tenn.

10. NAME OF FATHER: Standage

11. BIRTHPLACE OF FATHER (State or Country): dont Know

12. MAIDEN NAME OF MOTHER: Hicks

13. BIRTHPLACE OF MOTHER (State or Country): dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wm Orr
(Address) Halfway Oregon

15.
Filed 7-16-1914 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10" 1914, to July 11" 1914, that I last saw h.. alive on July 11" 1914, and that death occurred on the date stated above, at 3:28 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... yrs. 12 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Hagey M. D.

19 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: July 16 1914

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8457

Registered No. 44

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth A. Engle.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH. February 14 1841
(Month) (Day) (Year)

7. AGE 73 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)... for 37 years employed by John Wanamaker Philadelphia Pa.

9. BIRTHPLACE (State or Country) N York

10. NAME OF FATHER James Hutchins

11. BIRTHPLACE OF FATHER (State or Country) Cornwall England

12. MAIDEN NAME OF MOTHER Sarah Smith.

13. BIRTHPLACE OF MOTHER (State or Country) Lostiff England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. A. Stiry

(Address) Caldwell Idaho.

15. Filed July 21 1914 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to July 20 1914, that I last saw her alive on July 20 1914, and that death occured on the date stated above, at 9.00 P. M.

The CAUSE OF DEATH* was as follows:

Rupture of Aortic aneurism.

(Duration) Instant. Yrs. mos. ds.

Contributory (Secondary) Cathaggal Condition of lungs.

(Duration yrs. 6 mos. ds.

(Signed) John S. Meyer M. D.

7/21/1914 (Address) Caldwell Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Fernwood Cemetary Philadelphia. DATE OF BURIAL 8-2-1914

20. UNDERTAKER M. C. Dyer. ADDRESS Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8458

Registered No. 45

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

(No. ....., ... St.)

Registration District No. 3

Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward L Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 17 (Day) 1858 (Year)

7. AGE: 56 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: dont know

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: dont know

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Murphy

(Address) Caldwell, Idaho.

15. Filed 7-24-1914

John S. Meyer, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1914, to July 22 1914, that I last saw him alive on July 21 1914 and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Mellen M. D.

7-24 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cemetry — DATE OF BURIAL: 7-26-1914

20. UNDERTAKER: W. C. Myer — ADDRESS: Caldwell Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 1005

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8459

Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W Hodson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 26 (Day) 1839 (Year)

7. AGE: 75 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Vienna, Ohio.

10. NAME OF FATHER: Seaton Graham Hodson

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Margaret Downing

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. L. Sloan

(Address) Caldwell Idaho.

15. Filed Aug. 1st 1914 — John S. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1914, to July 31 1914, that I last saw h[illegible] alive on July 29 1914, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

..... (Duration) about Yrs. mos. ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) J. W. Kibler M. D.

8/1 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Aug 3 1914

20. UNDERTAKER: W C Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SDRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

File No. 5161

City of Lewiston Idaho (No. 522 Aid 16th St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Wilhelm Munhaus Thormahlen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 27th (Day) 1855 (Year)

7. AGE: 59 yrs. 4 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Labor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sulzwedeln Oldenburg Ger.

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. S. Brown

(Address) 1602 Carson Ave

15.

Filed Aug. 10 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5th 1914, to July 5th 1914, that I last saw h[illegible] alive on July 5th 1914 and that death occurred on the date stated above, at 7.20 P.M.

The CAUSE OF DEATH* was as follows:

Concussion of Brain
with Fracture of base

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Fall from wagon

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. C. Ingerson M. D.

7/5 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lenore Ida. | DATE OF BURIAL: 7/7 1914

20. UNDERTAKER: J. Carson | ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8462

Registered No. 2

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of ..... (No. ....., East Lewiston St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Peterson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 19 (Day) 1 (Year)

7. AGE: 56 yrs. — mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: John Richards

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Lydia Scott

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W F Peterson
(Address) Lewiston

15.
Filed Aug. 10- 1914 L J Carkin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 28th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1912, to July 28 1914, that I last saw her alive on July 28th 1914 and that death occurred on the date stated above, at 11-0 M.

The CAUSE OF DEATH* was as follows:

Im ~~Sept~~ Mitral incompetency

(Duration) 2 yrs. mos. ds.

Contributory (Secondary) Rheumatism

(Duration) — yrs. — mos. — ds.

(Signed) F P Browne M. D.

7/28 1914 (Address) F P Browne

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: City Cemetary — DATE OF BURIAL: 7/30 1914

20. UNDERTAKER: Vassar — ADDRESS: Lewiston Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2175
File No. 8463
Registered No. 20

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julian Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Jan (Month) 25 (Day) 1903 (Year)
7. AGE: 11 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Kansas
10. NAME OF FATHER: Humphrey Jones
11. BIRTHPLACE OF FATHER (State or Country): Ga
12. MAIDEN NAME OF MOTHER: Ida Lowery
13. BIRTHPLACE OF MOTHER (State or Country): Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. Jones
(Address) Ryks Ida
15. Filed Aug 6 1914 [illegible] Local Registrar

SYMS - YORK CO. PTG. & BDG. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 6 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1914, to Aug 6 1914, that I last saw him alive on Aug 6 1914, and that death occured on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. S. Fuller M. D.
8/6 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 day. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Taken off train
Former or usual residence Topeka Kansas

19. PLACE OF BURIAL OR REMOVAL: Topeka Kansas — DATE OF BURIAL: Aug 1914
20. UNDERTAKER: [illegible] Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville

City of Lincoln

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2150

(No. ....., ... St.)

File No. 8403

Registered No. 79

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chauncey W. Earl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH ~~June~~ Dec 8 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 7 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Child
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lincoln Ida

10. NAME OF FATHER Chauncey Earl

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Martha A Barlow

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chauncey Earl
(Address) RD #1 Idaho Falls

15. Filed Aug 4 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH ~~July~~ Aug. 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos Worley Cooper M. D.

Aug 7 1914 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lincoln, Ida	Aug 5 1914

20. UNDERTAKER	ADDRESS
C E Dunwoody	Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 73
County of Bonneville Primary Registration District No. 21 13
City of Ammon (No. ....., ... St.)
File No. 8465
Registered No. 74
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alvin H Wilson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feby 2 (Month) (Day) 1898 (Year)

7. AGE: 16 yrs. 5 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Bassett Wilson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Dora Allred

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bassett Wilson
(Address) Ammon Idaho

15. Filed July 30 1914 Ray Fenimore Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h— alive on ——— 191..., and that death occurred on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows: ———
Lumbar Endocarditis
Acute Medical Attendance
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray Fenimore M. D.
July 30 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grant Ida — DATE OF BURIAL: 7/30 1914

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

SYMS - YORK CO. PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8466

Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 78

Primary Registration District No. 2130

(No. .... St.)

1. PLACE OF DEATH.

County of Bingham

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Thomas Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 3 (Day) 1859 (Year)

7. AGE: 55 Yrs. 2 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)... Cigar Store

9. BIRTHPLACE (State or Country) La

10. NAME OF FATHER John Price

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Johnston
(Address) 1st Commercial State Blackfoot Ida.

15. Filed July 28 1914 Coleman Idaho
Local Registrar

SYMS-YORK CO., PTRS. & ENGS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1914, to July 24 1914, that I last saw him alive on July 24 1914, and that death occured on the date stated above, at 7 1/2 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. R. Dobunyeau M. D.

July 28 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Topeka Kansas — DATE OF BURIAL: July 1914

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2150
File No. 8468
Registered No. 72

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonora Weeks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov (Month) 4 (Day) 1901 (Year)

7. AGE
13 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE
(State or Country) Fairview Utah

10. NAME OF FATHER
Thos. Henry Weeks

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER
Harmon

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Henry Weeks
(Address) Irwin Ida

15.
Filed July 9 1914
Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 8 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1914, to July 8 1914, that I last saw him alive on July 8 1914, and that death occured on the date stated above, at 6:10 A. M.

The CAUSE OF DEATH* was as follows:
Appendicitis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... mos. ..... ds.

(Signed) L. L. Fuller M. D.
July 9 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Erwin - Ida. | DATE OF BURIAL: 7-10-1914

20. UNDERTAKER: Thos. W. Muhleman | ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 847
Registered No. 33

1. PLACE OF DEATH,
County of Franklin
City of Dayton
(No. ....., ... St.)

Registration District No. 27
Primary Registration District No. 2118

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Josephine Taylor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug 13 (Month) – 1913 (Day) 1 (Year)

7. AGE: ..... yrs. 11 mos. 4 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Salmon Idaho

10. NAME OF FATHER: Alvin E Taylor

11. BIRTHPLACE OF FATHER (State or Country): Harrisville Utah

12. MAIDEN NAME OF MOTHER: Florence Bassett

13. BIRTHPLACE OF MOTHER (State or Country): Bitter Root Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A W Taylor
(Address) Dayton Idaho

15.
Filed 7/20 1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1914, to July 18 1914
that I last saw h[illegible] alive on July 17 1914
and that death occurred on the date stated above, at 5:30 P. M.
The CAUSE OF DEATH* was as follows:
Erysipelas

..... (Duration) ✓ yrs. ✓ mos. 6 ds.
Contributory (Secondary) .....
..... (Duration) ✓ yrs. ✓ mos. ✓ ds.
(Signed) G W Staley M. D.
July 20 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clifton Idaho
DATE OF BURIAL: July 20 1914

20. UNDERTAKER: George Lundquist
ADDRESS: Logan Utah

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8472
Registered No. 34

1. PLACE OF DEATH.
County of Frankland
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clea Porter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: ~~July~~ Aug. (Month) ~~29th~~ 20 (Day) ~~1914~~ 1912 (Year)

7. AGE: yrs. I mos. II ds. 22
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: ---
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Preston Idaho

10. NAME OF FATHER: Albert E. Porter

11. BIRTHPLACE OF FATHER (State or Country): Preston Idaho

12. MAIDEN NAME OF MOTHER: Mary C. Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Franklin Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert E. Porter
(Address) Preston Idaho

15.
Filed ..... 191....
Dr Allen R Rudd
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 29 (Month) (Day) 1914 (Year) 191....

17. I HEREBY CERTIFY, That I attended deceased from July 29 191 4, to July 29 191 4
that I last saw her alive on July 29 191 4
and that death occurred on the date stated above, at 12 A M.

The CAUSE OF DEATH* was as follows:

Drounded in a canal
found dead

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen R Rudd M. D.
7/29 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho
DATE OF BURIAL: 7/30 1914

20. UNDERTAKER: None
ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

County of Idaho

Primary Registration District No. 2184

File No. 8473

City of Kooskia

(No. ....., ... St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Adora Squires

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 7 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward E. Squires

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Mary L. Tolett

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward E. Squires
(Address) Kooskia - Idaho

15.
Filed Aug. 1, 1914 J.M. Verbeckmoes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Death probably due to Caused from administering a cathartic a few hours after birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.M. Verbeckmoes M. D.
July 9 1914 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: July 9 1914

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

County of Idaho

Primary Registration District No. 2184

File No. 8171

City of ..... (No. ....., ... St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gustav Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

October 17 1861
(Month) (Day) (Year)

7. AGE

52 yrs. 9 mos. 8 ds. 21

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Johannes Larson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Louisa Larson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Selma Larson

(Address) R F D 1 Kaaskea Idaho

15.

Filed Aug 1 1914 J M Verbeck Mms
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 8 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to July 1914, that I last saw h.. alive on Dec. 1914 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Verbeck M. D.

July 9 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tabor Cemetery — DATE OF BURIAL: July 9 1914

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

County of Shoshone Primary Registration District No. 2124 File No. 8475

City of Harpster (No. ....., ... St.) Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Warrie Clarence Sallee

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 30 (Day) 1885 (Year)

7. AGE: 29 yrs. ..... mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Printer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: William Van Sallee

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Virginia Hunter

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bessie Zornes

(Address) Stites Idaho

15.

Filed Aug. 1. 1914 J.M. Vubuturno
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1914, to July 1. 1914, that I last saw him alive on July 1 1914 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.M. Vubuturno M. D.

July 26 1914 (Address) Kootenai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery - Stites

DATE OF BURIAL: July 26 1914

20. UNDERTAKER: Stites

ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 8477
Registered No. 51

1. PLACE OF DEATH.
County of Madison
City of Sutton (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Summers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): married

6. DATE OF BIRTH.
Dec. (Month) 4 (Day) 1857 (Year)

7. AGE
56 Yrs. 7 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Nicholas Summers

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Eliza Roar

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs [illegible]
(Address) Burton

15.
Filed 8-8 1914
G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21 1913, to 8-6 1914, that I last saw h[illegible] alive on 8-6 1914, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary)
.....(Duration) .....Yrs. .....mos. .....ds.
(Signed) G G Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton
DATE OF BURIAL: 8/9 1914

20. UNDERTAKER: John Phillips
ADDRESS: Rex.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 8478
Registered No. 52

1. PLACE OF DEATH.
County of Fremont
City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ross Flamm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 3 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 13 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jacob Herbert Flamm

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Della Larsen

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. F. Flamm
(Address) Rexburg, Ida

15. Filed 8-4 1914 Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1914, to Aug 3 1914, that I last saw h[illegible] alive on Aug 3 1914, and that death occured on the date stated above, at 3:20 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) G. F. Eaton M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg. DATE OF BURIAL: Aug 4 1914

20. UNDERTAKER: F. M. Williams ADDRESS: Rex

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYLES - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68
Primary Registration District No. 2176
File No. 8179
Registered No. 24

1. PLACE OF DEATH.
County of Jefferson
City of Rigby. R.D. 2 (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nat Samuel (Died Wyoming)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Bach

6. DATE OF BIRTH July 13 1914
(Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Bach

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER J. Clifford

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Viola Butler.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Clifford
(Address) Rigby. R.D. 2

15. Filed Aug 10 1914 Ray B. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 12 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1914, to July 12 1914, that I last saw h[illegible] alive on July 12 1914, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Atelectasis
Congenital Heart weakness

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. D. Tucker M. D.
19 (Address) Lewisville - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rigby | DATE OF BURIAL July 13 1914

20. UNDERTAKER Friends | ADDRESS Rigby-R.D. 2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19ZSO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Hawe

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 8181
Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Florence Walker

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: Apr 4 (Month) (Day) 1868 (Year)

7. AGE: 46 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Iowa.

10. NAME OF FATHER John Martin

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Rachel Martin

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev. Ford M. Bunten
(Address) Hawe Ida

15. Filed Aug 10 191 4 Roy D. Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 4 (Month) (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 191 4, to Apr 4 191 4
that I last saw h[er] alive on Apr 4 191 4
and that death occurred on the date stated above, at 10P. M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Fox M. D.
Apr 5 1914 (Address) Hawe Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hawe — DATE OF BURIAL: Apr. 6 191 4

20. UNDERTAKER: Friends — ADDRESS: Hawe - Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 8481

Name Mary Florence Walker

Date of Death Apr. 4, 1914.

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) E W Fox M.D.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 8482
Registered No. 11
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Eva May Forbes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 27 (Day) 1877 (Year)

7. AGE: 36 yrs. 8 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Joshua Cole

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Minnie Roberts

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Burt G Forbes
(Address): Payette Ida

15.
Filed July 8 1914. J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to July 7 1914 that I last saw h[illegible] alive on July 7 1914, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Dysentery

— (Duration) — yrs. — mos. 30 ds.

Contributory (Secondary): Acute Dementia

— (Duration) — yrs. — mos. 40 ds.

(Signed) J. C. Crouch M. D.
7-7-1914 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: July 8 1914

20. UNDERTAKER: Glenn C Landon
ADDRESS: Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

WYMS-YORK CO., PRINTERS & RINDERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No.
Registered No. 12
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edna Tiles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan 26 1869 (Month) (Day) (Year)

7. AGE: 45 yrs. 5 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Silas Snider.

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: unknown.

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Tiles
(Address) Blair Ida.

15. Filed July 19 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 16 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-15 1914, to 7-16 1914, that I last saw her alive on 7-16 1914, and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Hemorrage from ovarian abscess

(Duration) dont Known yrs. mos. ds.
Contributory (Secondary) ovarian abscess
(Duration) yrs. 2 mos. ds.

(Signed) G A Barton M. D.
7-17 1914 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida. DATE OF BURIAL: July 21 1914

20. UNDERTAKER: G. C. Landon. ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 818

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

1. PLACE OF DEATH.
County of Canyon
City of Payette (No. ..., ... St.)
Registration District No. 4
Primary Registration District No. 1008

2. FULL NAME Sam Polis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Greek
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
... (Month) ... (Day) 1 (Year)

7. AGE
71 yrs. ... mos. ... ds.
IF LESS than 1 day how many ..... *hrs.or* ..... *min.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ...

(Address) ...

15. Filed July 27 1914 J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191...
that I last saw h... alive on ... 191...,
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Unknown man found dead in Payette River near Payette, Idaho + identified by friends
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Woodward M. D.
July 27 1914 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser, Idaho — DATE OF BURIAL: July 28 1914

20. UNDERTAKER: Glenn C Landon — ADDRESS: Weiser

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

File No. 8485
Registered No. 14
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Creger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: July (Month) 28 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. D. Creger

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Gertrude Blayden

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Creger
(Address) Payette

15. Filed July 30 1914 J. O. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1914, to July 29 1914, that I last saw him alive on July 29 1914, and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) Four hours mos. ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

July 30 1914 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	July 30 1914

20. UNDERTAKER	ADDRESS
J. V. Cain	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8186

Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian

Registration District No. 11
Primary Registration District No. 2003.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Renner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: July (Month) 21 (Day) 1872 (Year)
7. AGE: 42 yrs. 0 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Michigan
10. NAME OF FATHER: Thomas Renner
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Lorena Green.
13. BIRTHPLACE OF MOTHER (State or Country): New York (State)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorena Renner
(Address) .....
15. Filed July 22 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 22 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 25 1914, to July 20th 1914 that I last saw him alive on July 14 1914 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver & Stomach + —

..... (Duration) 1 yrs. — mos. ..... ds.
Contributory (Secondary) Ulcer of stomach —
..... (Duration) 3 yrs. — mos. — ds.
(Signed) C. L. Dutton [redacted] M. D.
7/22 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: 7-23 1914
20. UNDERTAKER: [illegible] — ADDRESS: Meridian

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 9003
File No. 8187
Registered No. ____

1. PLACE OF DEATH.
County of Ada
City of Meridian
(No. near Young Station St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mettie Rea

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 6 (Day) 1881 (Year)

7. AGE: 33 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... none Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER T. C. Rea

11. BIRTHPLACE OF FATHER (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Martha Inman

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Vesta Rindall
(Address) ____

15. Filed Aug. 15 1914
C. L. Sutton
Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 14th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1914, to Aug 14 1914, that I last saw her alive on Aug 12 1914, and that death occured on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:
Valvular lesions of the heart—

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) General Anasarca
(Duration) most of her life yrs. ____ mos. ____ ds.

(Signed) C. L. Sutton M. D.
8/15 1914 (Address) Meridian Canada

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery | DATE OF BURIAL: 8/15 1914

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8488
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian
Registration District No. 11
Primary Registration District No. 2003
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Not Named.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Aug (Month) 6 (Day) 1914 (Year)
7. AGE: ✓ yrs. ✓ mos. ..... ds. IF LESS than 1 day how many 17 hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: - none
(b) General nature of industry business or establishment in which employed (or employer): - none
9. BIRTHPLACE (State or Country): Meridian
10. NAME OF FATHER: Harry J Apie.
11. BIRTHPLACE OF FATHER (State or Country): Nebraska
12. MAIDEN NAME OF MOTHER: Clara Hedges
13. BIRTHPLACE OF MOTHER (State or Country): Nebraska
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Apie
(Address) Meridian Ida
15.
Filed Aug 7 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 7 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1914, to Aug 7 1914 that I last saw him alive on Aug 7 1914 and that death occurred on the date stated above, at 5:30 P. M.
The CAUSE OF DEATH* was as follows:
Asphyxia by Strangulation
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Atelectasis.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Dutton M. D.
Aug 7 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery
DATE OF BURIAL: 8-8-1914
20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

Primary Registration District No. 2057

File No. 8489

County of Latah

City of Palouse (No. ....., ... St.)

Registered No. 475

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry H Boyington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 22 (Day) 1887 (Year)

7. AGE: 27 yrs. 6 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota.

10. NAME OF FATHER: Henry Boyington

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Caroline Pierce

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Boyington
(Address) Palouse Idaho

15. Filed 8/10 1914 D D Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to July 27 1914
that I last saw h..... alive on " " 1914
and that death occurred on the date stated above, at 7.4 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Freeman M. D.

7/27 1914 (Address) Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Palouse Idaho | DATE OF BURIAL: July 29 1914

20. UNDERTAKER: C E Bolt and Sons | ADDRESS: Palouse Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1 2
Primary Registration District No. 2057
(No.) St.)

File No. 8490
Registered No. 424
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
(Month) (Day) 1868 (Year)

7. AGE 46 yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber jack
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ky

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D Brennan
(Address)

15. Filed 8/10 1914 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to July 12 1914, that I last saw h alive on 4 1 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D D Brennan M. D.
July 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
191...

20. UNDERTAKER | ADDRESS
C E Bobo and Sons

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Athol
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 14
Primary Registration District No. 2051
(No. ....., ... St.)

File No. 8491
Registered No. 423
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Ward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F.	W	S.

6. DATE OF BIRTH
July (Month) 1 (Day) 13 (Year)

7. AGE
1hr yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Nil
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Saint Paul

10. NAME OF FATHER Elias Ward

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elias Ward
(Address) Graciti

15.
Filed 8/10 1914 D D Freeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
7 (Month) — 13 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to 7-13 191 4,
that I last saw h..... alive on 7-13 191 4
and that death occurred on the date stated above, at 1¼ M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Freeman M. D.
7/14 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Athol	7-14 1914
20. UNDERTAKER	ADDRESS
Pace	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17

Primary Registration District No. 2057

File No. 8402

Registered No. 4822

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (un-named) Johnson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Single

6. DATE OF BIRTH: July (Month) 7 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. 11 hrs
IF LESS than 1 day how many ..11.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rathdrum Idaho

10. NAME OF FATHER [redacted] O Johnson

11. BIRTHPLACE OF FATHER (State or Country) Detroit Maine

12. MAIDEN NAME OF MOTHER Selma Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Detroit Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A Sayers
(Address) Spokane Wash

15. Filed 8/10 1914 D D Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7. 1914, to July 7. 1914, that I last saw him alive on July 7. 1914, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth

11 hrs
(Duration) — yrs. — mos. — ds.

Contributory —
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank P Vern M. D.
7/8 1914 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: C & Bobs Rathdrum — DATE OF BURIAL: 7-8 1914

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Arrowrock

Registration District No. 11
Primary Registration District No. 2131
(No. ..... St.)

File No. 8493
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Wilbur Stark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.)
6. DATE OF BIRTH. Nov. (Month) 3 (Day) 1892 (Year)
7. AGE: 21 Yrs. 7 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Minn.
10. NAME OF FATHER: S. H. Stark
11. BIRTHPLACE OF FATHER (State or Country): Conn.
12. MAIDEN NAME OF MOTHER: Celia Pettis
13. BIRTHPLACE OF MOTHER (State or Country): Minn.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Edna R. Stark
(Address) Parma, Ida.
15. Filed ..... 191 .....
J. P. Kerby, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 27 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 27 1914 to June 27 1914, that I last saw him alive on June 27 1914, and that death occured on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Fracture of skull (base) — accidental. 2 hrs.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cardiac failure ½ hr.
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) James P. Kerby M. D.
June 27 1914. (Address) Arrowrock, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State 2 hrs yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence Parma, Ida.

19. PLACE OF BURIAL, CREMATION: Roswell, Ida. DATE OF BURIAL: ..... 191 .....
20. UNDERTAKER ..... ADDRESS .....

BYRON - TOMLIN CO., PTRS. & BOOK. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8494

Registered No. .....

1. PLACE OF DEATH.

County of Lemhi

City of .....

(No. ..... St.)

Registration District No. 42

Primary Registration District No. 2153

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Troy L. Purcell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 6 (Day) 1843 (Year)

7. AGE: 71 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... H'wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Moses Winters

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Anna Penny

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Troy L. Purcell
(Address) 611 Grand Ave., Long Beach California

15. Filed Aug 1 1914 John W. Storey Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1914, to July 30 1914, (that I last saw her alive on July 30 1914, and that death occured on the date stated above, at 5-30 P M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Uremia

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John W. Storey M. D.

Aug 1 1914 (Address) Gilmore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lemhi county

DATE OF BURIAL: Aug 1 1914

20. UNDERTAKER: Geo Martin acting

ADDRESS: Leadore

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 53

County of Bear Lake

Primary Registration District No. 2432

File No. 8495

City of St Charles (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andreas Jens Michelsen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: June (Month) 4 (Day) 1889 (Year)

7. AGE: 25 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): St Charles

10. NAME OF FATHER: Jacob Michelsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Susana Barker

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susana Michalson
(Address) St Charles

15. Filed Aug 22 1914 John Mattson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Killed by Lightning
at St Charles
August 6 1914
(Duration) ..... yrs. ..... mos. ..... ds.
~~Contributory (Secondary)~~ No Dr in attendance
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence St Charles

19. PLACE OF BURIAL OR REMOVAL: St Charles | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: J. A. Blade | ADDRESS: St Charles

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., BKS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2131
(No. ....., ... St.)

File No. 8406
Registered No. .....

1. PLACE OF DEATH.
County of Boise
City of Arrowrock

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Bryant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. ? (Month) ..... 1 (Day) ..... (Year)

7. AGE: 65 Yrs. (about) Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (Camp maintenance)

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James P Kerby, Md
(Address) Arrowrock, Ida

15. Filed July 16 1914 J P Kerby Md Local Registrar

SYMS - YORK CO., PTRS. & LITHS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1914, to July 16 1914, that I last saw h[illegible] alive on July 16 1914, and that death occured on the date stated above, at 12.30 P. M.

The CAUSE OF DEATH* was as follows:
Found dead
When examined about 1 month ago was suffering from mitral regurgitation
Hepatic asthma
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James P Kerby M. D.
July 16 1914 (Address) Arrowrock Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State. about ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ?
Former or usual residence ?

19. PLACE OF BURIAL OR REMOVAL: Boise Ida. DATE OF BURIAL ..... 191...

20. UNDERTAKER: Shreiber & Suddenfadden ADDRESS Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of —
(No. ——, ——— St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048
File No. 8497
Registered No. 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Wolford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept 10 (Month) (Day) 1858 (Year)

7. AGE: 55 yrs. 11 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John D. Moore

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Mary Babet

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Geo Ford
(Address): P.O. Box 4, Ida

15. Filed Aug 12, 1914 Ellis Neary Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 20 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1914, to July 20 1914, that I last saw h[illegible] alive on July 20 1914 and that death occurred on the date stated above, at 6 P M.

The ~~CAUSE OF DEATH~~* was as follows:
Acute Cerebral Rheumatism

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) Ellis Neary M. D.
Aug 6 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bancroft — DATE OF BURIAL: July 23 1914

20. UNDERTAKER: O. A. Schumacher — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8495
Registered No. 31

1. PLACE OF DEATH.
County of Bannock
City of Cleveland

Registration District No. 11
Primary Registration District No. 2048
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorthea Jensen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1859 (Year)

7. AGE: 55 yrs. 8 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Orslev Fyen Denmark

10. NAME OF FATHER: Rasmus Hansen

11. BIRTHPLACE OF FATHER (State or Country): Orslev Fyen Denmark

12. MAIDEN NAME OF MOTHER: Ane Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Orslev Fyen Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Londgreen
(Address) Treasureton Idaho

15. Filed Aug 10, 1914 Eva Kaercy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1913, to Aug 4, 1914, that I last saw h en alive on Aug 4th 1914 and that death occurred on the date stated above, at 3:50 P.M.

The CAUSE OF DEATH* was as follows:
Inflamatory Rheumatism

..... (Duration) 1 yrs. 8 mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eva Kaercy M. D.
Aug 10, 1914 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cleveland Idaho
DATE OF BURIAL: Aug 7 1914

20. UNDERTAKER: B F Lamm
ADDRESS: Cleveland

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8499
Registered No. 32

1. PLACE OF DEATH.
County of Canyon
City of Soda Springs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2048
(No. ——, ——— St.)

2. FULL NAME ———

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 2 (Day) 94 (Year)

7. AGE: — yrs. — mos. — ds. IF LESS than 1 day how many 1 hrs. or ——— min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: ———
(b) General nature of industry business or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country): Soda Springs

10. NAME OF FATHER: Earl Smith

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Nina Rawley

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr Kaney
(Address) Soda Springs

15.
Filed Aug 10, 1914 Ellis Kaney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1914, to Aug 2 1914, that I last saw h— alive on Aug 2 1914, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows: Congestion of Lungs

——— (Duration) ——— yrs. ——— mos. ——— ds.

Contributory (Secondary) ———

——— (Duration) ——— yrs. ——— mos. ——— ds.

(Signed) Ellis Kaney M. D.

Aug 10, 1914. (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ——yrs. ——mos. ——ds. In the State ——yrs. ——mos. ——ds.
Where was disease contracted, if not at place of death? ———
Former or usual residence ———

19. PLACE OF BURIAL OR REMOVAL: Soda Springs
DATE OF BURIAL: Aug 3, 1914

20. UNDERTAKER: Ed-Whitman
ADDRESS: Soda Spgs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8500

Registered No. 2

1. PLACE OF DEATH.
County of Minidoka
City of Heyburn
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18
Primary Registration District No. 2102
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Harvey Hellewell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug. (Month) 9 (Day) 1857 (Year)

7. AGE: 56 yrs. 9 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogden Utah Weber Co

10. NAME OF FATHER: Robert Hellewell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elisabeth Tanor

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pearl Lochhead
(Address) 835-26th Ogden Utah.

15. Filed July. 10 1914 V. P. Tillow Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1914 to May 21 1914, that I last saw h alive on May 21 1914 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(Duration) 3 yrs. — mos. — ds.
Contributory (Secondary) Hemorrhage Pulmonary
(Duration) — yrs. 3 mos. — ds.

(Signed) W. L. Thompson M. D.
19 (Address) Heyburn Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: May 23 1914

20. UNDERTAKER: Lalloglys — ADDRESS: Rupert

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No. 8501
Registered No. 33

1. PLACE OF DEATH.
County of Cassia
City of Chesterfield
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Catherine Whitworth
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: July (Month) 25 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: John T. Whitworth
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Katherine Mills
13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T. Whitworth
(Address) Chesterfield

15. Filed Aug 10, 1914 Ezra Kaye Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1914, to July 25 1914, that I last saw her alive on July 25 1914, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Asthenia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Russell J. Smith M. D.
Aug 7 1914 (Address) Declo

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chesterfield
DATE OF BURIAL: July 26 1914
20. UNDERTAKER: none
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 1011
File No. 8502
Registered No. 57

1. PLACE OF DEATH
County of Shoshone
City of Wallace
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert J. C. Osborne

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 24 Yrs. 9 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: mill man
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Geo. N. Osborne

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Lizzie Cleland

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas H Osborne
(Address) Black Lake Ida

15. Filed May 29 1914 F Leo Dunphy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1914, to July 29 1914, that I last saw him alive on July 27 1914, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Dr Dis following traumatic injury to right left left arm
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Howey M. D.
July 30 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. 19 days. In the State .....yrs. .....mos. .....days
Where was disease contracted if not at place of death? Mullan Ida
Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: July 30 1914

20. UNDERTAKER: Hand Undertaking Co.
ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70

Primary Registration District No. 1011

File No. 8503

Registered No. 50

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Beatrice Jefferson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 4 Yrs. ..... Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Ralph Jefferson

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Bessie Kelley

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bessie Jefferson

(Address) Wallace Idaho

15. Filed 7/27 1914 St. Leo Tingley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1914, to July 27 1914, that I last saw h alive on July 26 1914, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Acute gastro enteritis

(Duration) ..... yrs. 1½ mos. ..... ds.

(Signed) Thomas E. Stevens M. D.

19..... (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 9 days. In the State ..... yrs. ..... mos. 9 days

Where was disease contracted if not at place of death? Residence

Former or usual residence Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL ..... 191..

20. UNDERTAKER: Woods Undertaking Co — ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 10

Primary Registration District No. 1011

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8504

Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orville Merritt

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 18 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: J. N. Merritt

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Tom Durand

(Address) Dudley Idaho

15. Filed July 20 1914 F. Leo Lynch Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16. 1914., to July 19 1914, that I last saw him alive on July 18 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. St. John M. D.

19..... (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldi Ida — DATE OF BURIAL: July 20 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No.
File No. 8505
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Nelson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January (Month) 16 (Day) 1864 (Year)

7. AGE: 80 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St. Charles, Id. Bear Lake Co

10. NAME OF FATHER: Rasmus Peter Nelson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Wilhelmina Anderstedt

13. BIRTHPLACE OF MOTHER (State or Country): Malmo, Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes Nelson
(Address) St Charles

15.
Filed Aug 27 1914 John Mattson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1914, to July 5 1914, that I last saw him alive on July 5th 1914, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Myocarditis and Nephritis

(Duration) ? yrs. 3 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Aug 26 1914 (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles | DATE OF BURIAL: July 7 1914

20. UNDERTAKER: J. A. Bleak | ADDRESS: St Charles

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8506
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Juliaetta
(No. ....., ... St.)

Registration District No. .....
Primary Registration District No. 2148.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Infant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 12 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ½ ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Juliaetta Ida

10. NAME OF FATHER: Earl A. Pierce

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Anna M. King

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl A. Pierce
(Address) .....

15.
Filed Aug 13 1914 — A. A. Roe, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw him alive on Aug 13 1914
and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Premature birth, with failure of heart & circulation to adjust to breathing
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Roe M. D.
Aug 13, 1914 (Address) Juliaetta, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta, Ida
DATE OF BURIAL: Aug 13 1914

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 8507
Registered No. 10

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen L Follett
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
June (Month) 6 (Day) 1831 (Year)

7. AGE
83 yrs. 2 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) St. Lawrence Co N.Y.

10. NAME OF FATHER
Shubl Willson

11. BIRTHPLACE OF FATHER
(State or Country) N.Y.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. V. Follett
(Address) Genesee

15.
Filed Aug 18 1914 W. H. Cheer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1914 to Aug 17 1914
that I last saw h.er alive on Aug 17 1914
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) — yrs. — mos. 2 ds.
Contributory Arteriosclerosis
(Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) W. H. Cheer M. D.
8-18 1914 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL I.O.O.F. | DATE OF BURIAL 8-19 1914

20. UNDERTAKER F. E. Lambert | ADDRESS Princeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTG. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 8508
Registered No. 9

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Kimbel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Boy	white	

6. DATE OF BIRTH: June (Month) 24 (Day) 1911 (Year)

7. AGE: 3 yrs. 1 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Genesee, Idaho

10. NAME OF FATHER John Kimbel

11. BIRTHPLACE OF FATHER (State or Country) Ft. Recovery, Ohio

12. MAIDEN NAME OF MOTHER Elizabeth Abels

13. BIRTHPLACE OF MOTHER (State or Country) Philothea, Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Kimbel
(Address) .....

15. Filed 8-8 1914 W. N. Rhea Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1914, to Aug 1914, that I last saw h in alive on Aug 7 1914 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows: Tumors involving Optic nerve Skull and Chiasm

(Duration) 1 yrs. 2 mos. ..... ds.

Contributory (Secondary) 2

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Thorny M. D.

8-8 1914 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cath. Cem	8-9 1914

20. UNDERTAKER	ADDRESS
E. Lambert	Genesee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2146
File No. 85(14)
Registered No. 2

1. PLACE OF DEATH.
County of Lalah
City of Boyill
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herbert Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Not Known 1
(Month) (Day) (Year)

7. AGE
about
19 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) ..... Fire Patrol for P.L.Co.

9. BIRTHPLACE
(State or Country) Indiana

10. NAME OF FATHER
not Known

11. BIRTHPLACE OF FATHER
(State or Country) ~~~

12. MAIDEN NAME OF MOTHER
~~~

13. BIRTHPLACE OF MOTHER
(State or Country) ~~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J.P. Jones Supt P.L. Co
(Address) Boyill Ida

15.
Filed Aug 24 1914 J.L. Champine
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August 13th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
accidental injury caused
by falling tree on fire Patrol

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F.L. Gibson M. D.
8/13 1914 (Address) Boyill Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boyill Ida	Aug 23d 1914

20. UNDERTAKER	ADDRESS
J.L. Champine	Boyill Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760
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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Bovill
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 8510
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stas Medonska

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 19 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): Fire Patrol P.L. Co.

9. BIRTHPLACE (State or Country): Montenegro

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.B. Pollock
(Address) Bovill Ida

15.
Filed 8/28 1914
J. Champine
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 25, 1914, to aug 25 1914, that I last saw h alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Shock
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Traumatic Amputation both legs
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F.L. Gibson M. D.
8/25 1914 (Address) Bovill Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Bovill Ida
DATE OF BURIAL: 8/28 1914

20. UNDERTAKER: J. Champine
ADDRESS: Bovill Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2146
File No. 8511
Registered No. 2

1. PLACE OF DEATH.
County of Latah
City of Bovill
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unknown Man

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: about 45 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): Fire Patrol, P. L. Co.

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: not Known

11. BIRTHPLACE OF FATHER (State or Country): Do

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B. Black
(Address) Bovill Ida

15.
Filed Aug 27 1914 J. L. Champion
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
8 (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1914, to Aug 27 1914; that I last saw h[illegible] alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental injury
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Falling tree
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. L. Gibson M. D.
8-27 1914 (Address) Bovill Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Wn
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: C L Shuss
ADDRESS: Colfax Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 42
County of Nezperce Primary Registration District No. 2170.
City of Robinson (No. ....., ... St.)
File No. 8512
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcia Hill

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Girl	White	Neither

6. DATE OF BIRTH Feby 27 1905
(Month) (Day) (Year)

7. AGE 9 yrs. 5 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) School Girl.

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Frank L. Hill

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Addie Simmons

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Howard
(Address) Gifford, Idaho.

15.
Filed 8-4 1914 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 3rd 1914.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18th 1914, to Aug 3rd 1914
that I last saw h.. alive on Aug 1st 1914
and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Infantile Paralysis

..... (Duration) ..... yrs. ..... mos. 20 ds.
Contributory (Secondary) Heart Complications
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Doctor Lovelace M. D.
..... 19..... (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Melrose Ida — DATE OF BURIAL 8-5 1914

20. UNDERTAKER E & S. Howard (acting) — ADDRESS Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2 8513
Registered No. 8

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. Otto Tezewbach St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92
Primary Registration District No. 2170

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Otto Tezewbach

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married, ~~Widower~~

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1863 (Year)

7. AGE: 50 yrs. 7 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Tezewbach.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sant Kuow.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Tezewbach
(Address) Coeur d'Alene Ida.

15. Filed 8 – 4 1914 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 4th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1914, to Aug 4th 1914 that I last saw h[illegible] alive on July 25 1914 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Cancer of Liver

(Duration) 2 yrs. — mos. — ds.
Contributory (Secondary) Anemia
(Duration) 1 yrs. — mos. — ds.

(Signed) J. J. Hemingtone M. D.
Aug 4th 1914 (Address) Gifford Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: German Luth Cem
DATE OF BURIAL: 8 – 7 1914

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2 851
Registered No. 9

1. PLACE OF DEATH.
County of Nez Perce
City of Lookout (No. ....., ... St.)

Registration District No. 92
Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willis Lee Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 2 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Ward L. Smith

11. BIRTHPLACE OF FATHER (State or Country): W. Va.

12. MAIDEN NAME OF MOTHER: Ollie Sperr

13. BIRTHPLACE OF MOTHER (State or Country): Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Smith
(Address) Lookout

15.
Filed 8-13 1914 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to Aug 9 1914
that I last saw him alive on Aug 9 1914
and that death occurred on the date stated above, at 12 a. M.
The CAUSE OF DEATH* was as follows:
Marasmus

..... (Duration) ..... yrs. 2 mos. 11 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Watts M. D.
..... 19..... (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lookout
DATE OF BURIAL: 8-14 1914

20. UNDERTAKER: W. E. Sams
ADDRESS: Lookout

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

Primary Registration District No. 20 11

File No. 8515

County of Adams

City of Council (No. ....., ... St.)

Registered No. 57-B

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph A. Fredrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Oct (Month) 6 (Day) 1838 (Year)

7. AGE: 76 yrs. 9 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Addison Missman

(Address) Council Idaho

15. Filed 7-19- 1914 Frank E Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on 7-18 1914,
and that death occurred on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilitation of heart

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Alcoholism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E Brown M. D.

7-19 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Council	7-19 1914
20. UNDERTAKER	ADDRESS
Cox & Young	Council

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Adams

Primary Registration District No. 20 11

City of Council

(No. ....., ... St.)

File No. 8516

Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Spelias

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Greek-

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: — (Month) — (Day) 1892 (Year)

7. AGE: 22 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Hand
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: S. Spelias

11. BIRTHPLACE OF FATHER (State or Country): Grece

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Greece —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nick Katchos
(Address) Council Idaho

15.
Filed 8-5 1914 Frank E Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
8 (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Struck by lightening. No Physician present or called. Was was Killed instantly. Information given by Nick Katchos.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde Ed Watson M. D.
8/4 1914 (Address) Council.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida. | DATE OF BURIAL: 8/5 1914

20. UNDERTAKER: Robert Young | ADDRESS: Council.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Adams

Primary Registration District No. 30 41

File No. 8517

City of Council (No. ....., ... St.)

Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vernie Compton

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 20 (Day) 1911 (Year)

7. AGE: 3 yrs. 3 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Midvale

10. NAME OF FATHER: B F Compton

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Ella Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B F Compton
(Address) Midvale

15.
Filed 8-21- 1914 Frank E Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 20 1914, to 20 1914 that I last saw h[illegible] alive on 10:30 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Run over by wagon

(Duration) about two minutes yrs. mos. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E. Brown M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale | DATE OF BURIAL: 8-22-1914

20. UNDERTAKER: Ryan | ADDRESS: Council

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

Primary Registration District No. 2011

File No. 8518

County of Adams

City of Council (No. ....., ... St.)

Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harrison H. New

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	WHT	Married

6. DATE OF BIRTH: April (Month) 6 (Day) 1841 (Year)

7. AGE: 73 yrs. 4 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Augus New

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Kitty Lieb

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. C. Lynn
(Address) Council Idaho

15. Filed 9-3 1914 Frank E Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1914, to Aug 1914, that I last saw h in alive on July 18 191, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebellar disease

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E Brown M. D.

8-22 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Council	8-23 1914

20. UNDERTAKER	ADDRESS
Robinson	Council

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 87

Primary Registration District No. 2164

File No. 8519

County of Washington

City of Cambridge (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William C Moseman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 7 (Day) 1864 (Year)

7. AGE: 50 yrs. 0 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Holland

10. NAME OF FATHER: H P Moseman

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Wilhimine Tofer

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Moseman
(Address) Salubria Ida.

15. Filed July 30 1914 C E Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to July 21 1914, that I last saw him alive on July 20 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage of Left Heart with Arteriosclerosis

(Duration) ..... yrs. ..... mos. 18 ds.

Contributory (Secondary) Fatty degeneration of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Schmuck M. D.

July 1 1914 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salubria — DATE OF BURIAL: July 22 1914

20. UNDERTAKER: Jas Hutchison — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS-WORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 8520
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily M. Lee Damm

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: July (Month) 26 (Day) 1890 (Year)

7. AGE: 24 yrs. ..... mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lonnys Lonns

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary Adams

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Baker.
(Address) Cambridge Ida.

15.
Filed Aug 13 1914 C E Schwartz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1914, to Aug 10 1914, that I last saw her alive on Aug 10 1914, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
T. B. of Lungs
.....
.....
(Duration) 4 yrs. ..... mos. ..... ds.
Contributory (Secondary) Contracted from Father
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Schwartz M. D.
Aug 13 1914 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Salubria — DATE OF BURIAL: Aug 11 1914

20. UNDERTAKER: J A Henderson — ADDRESS: Cambridge

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 88

Primary Registration District No. 2164

File No. 8521

County of Washington

City of Cambridge (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Ledington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 6 (Day) 1 1832 (Year)

7. AGE: 74 yrs. 9 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mosuna Buckhan Co

10. NAME OF FATHER: Thomas Ledington

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Lucinda Hendrick

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. C. Ledington
(Address) Weiser Ida.

15. Filed Aug 6 - 1914 C E Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914, to Aug 6 1914, that I last saw h in alive on Aug 6 1914, and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:
Paralysis Cerebri
.....
.....
(Duration) ..... yrs. ..... mos. 17 ds.

Contributory (Secondary) Rheumatism
(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) C E Schmuck M. D.
Aug 6 1914 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salubria — DATE OF BURIAL: Aug 7 1914

20. UNDERTAKER: J M Hudson — ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 58

Primary Registration District No. 2164

File No. 8522

County of Washington

City of Cambridge (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elisabeth J. Ensign

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 20 (Day) 1857 (Year)

7. AGE: 56 yrs. 6 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Frank

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Staley

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo E Ensign
(Address) Cambridge Idaho

15. Filed July 1 1914 C E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1914, to June 25 1914, that I last saw h[illegible] alive on June 25 1914, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

..... (Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Schmutz M. D.

July 1 1914 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton — DATE OF BURIAL: June 26 1914

20. UNDERTAKER: J C Anderson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8523
Registered No. 165

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. Cor 2d Colorado Ave St.) South Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Drucilla E. Loy.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. Nov (Month) 18th (Day) 1832 (Year)
7. AGE: 81 Yrs. 7 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Kentucky
10. NAME OF FATHER Jas. McCollom
11. BIRTHPLACE OF FATHER (State or Country) Ky
12. MAIDEN NAME OF MOTHER Louisa Tucker
13. BIRTHPLACE OF MOTHER (State or Country) Ky
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. Loy
(Address).....
15. Filed 7-1 1914 W S Parker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 30th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 15th 1914, to June 30th 1914, that I last saw h[illegible] alive on June 25th 1914, and that death occured on the date stated above, at 4 A. M.
The CAUSE OF DEATH* was as follows: Carcinoma of breast.
(Duration) 2 Yrs. — mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John Beck M. D.
June 30 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 2 1914
20. UNDERTAKER: Schrader & Sidenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Dr. Beck.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 8524

Registered No. 168

County of Ada

City of Boise

(No. St Lukes Hos. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James A. W. Mansur

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Not Obtainable 1844 (Month) (Day) (Year)

7. AGE: 70 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.? —

8. OCCUPATION
(a) Trade, profession or particular kind of work... Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Not Obtainable

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Burnett
(Address) Soldiers Home

15. Filed 7-5 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ 191 ~~to~~ saw 191 ~~that I last saw h~~ alive on dead 191 and that death occured on the date stated above, at 3.45 P. M.

The CAUSE OF DEATH* was as follows:
Accident
Struck by automobile

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Adolph S. Shreiber M. D.

19..... (Address) Boise Idaho Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death.....yrs.....mos.....days In this State.....yrs.....mos.....days
St Lukes Hos. 7 hours.
Where was disease contracted if not at place of death?.....
Former or usual residence Soldiers Home Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 5 1914

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 8525
Registered No. 169

1. PLACE OF DEATH.
County of Ada
City of South Boise (No. South Boise St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Etta Helen Atkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Jan (Month) 1 (Day) 1880 (Year)
7. AGE: 34 Yrs. 6 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) New York
10. NAME OF FATHER W W Irish
11. BIRTHPLACE OF FATHER (State or Country) New York
12. MAIDEN NAME OF MOTHER Susan Bailey
13. BIRTHPLACE OF MOTHER (State or Country) New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jay E. Hollenbeck
(Address) RR #4 Boise Idaho
15.
Filed 7-6 1914 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 191 4 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 1st 1914 to May 15 1914,
that I last saw her alive on May 13 191 ,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cancer
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Geo Calbeck M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 7 1914
20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7

Primary Registration District No. 1004

File No. 8526

Registered No. 170

1. PLACE OF DEATH.

County of Boise

City of Ada.

(No. St Alphonsus Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Giles G. Matheus.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sep (Month) 26 (Day) 1882 (Year)

7. AGE: 31 Yrs. 9 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Real Estate.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dealer.

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER John H. Matheus.

11. BIRTHPLACE OF FATHER (State or Country) Illinois.

12. MAIDEN NAME OF MOTHER Mary N. Stickland

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary H Matheus
(Address) Boise Idaho

15. Filed 7-6 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1914, to July 4 1914, and that I last saw h[illegible] alive on July 4 1914, and that death occured on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Anaemia, & Cast of degenerative fever, following Gastro-enterostomy Melancholia.

(Duration) ..... Yrs. ..... mos. 18 ds.

Contributory (Secondary) Chronic ulcers in st

Cause (Duration 12 yrs. ..... mos. ..... ds.

(Signed) L. O McCalla M. D.

7/6 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 7 1914

20. UNDERTAKER: Troy & Summers — ADDRESS: Boise Idy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8527

Registered No. 171

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 413 South 5½ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernard Quigley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unobtainable (Month) 1 (Day) (Year)

7. AGE: About 67 Years ... Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: [illegible] Unobtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O'Regan

(Address) Boise Idaho

15. Filed 7-9 1914 W. S. Parker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191... to ... 191...,

that I last saw him alive on July 3 1914,

and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis and Valvular heart disease

(Duration) Several years — Yrs. mos. ds.

Contributory (Secondary) ... (Duration ... yrs. ... mos. ... ds.

(Signed) W. B. Lyman M. D.

19... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: July 9 1914

20. UNDERTAKER: Schreiber & Lidenfelden — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8528

Registered No. 172

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME D. J. Hodges

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. (Month) not Obtainable (Day) 1 (Year) 1857

7. AGE: 57 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Horse Trader and Proprietor of Corrall

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Hodges

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Charlotte Hodges

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harvey Baxter

(Address) Boise, Idaho.

15. Filed 7-8 191 4

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 191 4, to July 5 191 4, that I last saw him alive on July 5 191 4, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal stasis from fecal impaction.

(Duration) — Yrs. — mos. 1 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Sloan M. D.

19 ..... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs ..... mos. ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence Oregon

19. PLACE OF BURIAL OR REMOVAL: Grand Rapids Mich — DATE OF BURIAL: 7/9 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

BYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8529

Registered No. 173

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1094

(If not in hospital, give street address) 1729 West Front St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Kent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 14th 1897 (Month) (Day) (Year)

7. AGE: 16 Yrs. 9 Mos. — ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Geo Kent

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Ida West

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Kent

(Address) Boise Ida

15. Filed 7-13 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12th 1914, to July 13th 1914, that I last saw him alive on July 12th 1914, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 7 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Jno R Nuzum M. D.

July 13 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence 1729 Front St. Boise Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/13 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 108 Leta St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 174 8530

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josiah Collins Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. June (Month) 13 (Day) 1914 (Year)

7. AGE ....Yrs....Mos. 1 ds. 2

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Marsing Ida

10. NAME OF FATHER Arthur R. Bradley

11. BIRTHPLACE OF FATHER (State or Country) Kas.

12. MAIDEN NAME OF MOTHER Della Heber

13. BIRTHPLACE OF MOTHER (State or Country) Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A R Bradley
(Address) Boise Ida

15. Filed July 15th, 1914 W. E. Baker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1914, to July 14 1914, that I last saw h[illegible] alive on July 14 1914, and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:
Cause unknown
Probably toxic nephritis

.....(Duration) ....Yrs....mos....ds.

Contributory (Secondary) .....
.....(Duration ....yrs....mos....ds.

(Signed) L D McCabe M. D.
19.... (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Marsing Idaho — DATE OF BURIAL 7/15 1914

20. UNDERTAKER Schreiber & Sidenfaden — ADDRESS Boise

Mr. Bradley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8531
Registered No. 175

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 817 N. 20th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Jeannette Stubblefield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan. (Month) 10 (Day) 1856 (Year)

7. AGE: 58 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: David H. Cowan

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Eliza Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edith Stubblefield
(Address) 817 N 20 Boise.

15.
Filed 7-15 1914
M S Parker
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1914, to July 13 1914, that I last saw h[illegible] alive on July 13 1914, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes mellitus
(Duration) 5 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) M. H. Dallmann M. D.
7/15 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/16 1914

20. UNDERTAKER: Schreiber & Siefenfaden — ADDRESS: Boise Idaho.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 10-4

(No. 410 State St.)

File No. 8532

Registered No. 176

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander H. McDonald

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. not Abtainable 1834 (Month) (Day) (Year)

7. AGE: about 80 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: not abtainable

11. BIRTHPLACE OF FATHER (State or Country): not abtainable

12. MAIDEN NAME OF MOTHER: not Abtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Abtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry W. Baker
(Address) Boise

15. Filed 7-18 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1914, to July 16 1914, that I last saw him alive on July 16 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Senile decay

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) L P McCalla M. D.

7/17 1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Reynolds Creek Cemetery Boise Idaho — DATE OF BURIAL: July 20 1914

20. UNDERTAKER: Schreiber & Hildenbrand — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PRINTERS & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8533
Registered No. 137

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1204 E. State St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Hoagland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. July (Month) 19th (Day) 1914 (Year)
7. AGE: ... Yrs. ... Mos. 1 Ds. IF LESS than 1 day how many ... hrs. or ... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Boise, Idaho.
10. NAME OF FATHER: J. D. Hoagland
11. BIRTHPLACE OF FATHER (State or Country): Utah.
12. MAIDEN NAME OF MOTHER: Rilla Hatfield
13. BIRTHPLACE OF MOTHER (State or Country): Mont.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. D. Hoagland
(Address) Boise, Idaho.
15. Filed 7-20 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 19 1914, to July 20 1914, that I last saw him alive on ... 191..., and that death occured on the date stated above, at 4 A. M.
The CAUSE OF DEATH* was as follows:
Premature
(Duration) ... Yrs. ... mos. 2 ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.
(Signed) M S Parker M. D.
(Address) Boise
7-20 1914

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7-20-1914
20. UNDERTAKER: Schneider & Sidenfaden — ADDRESS: Boise, Ida.

Dr. Tibbs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. V

Primary Registration District No. 1004

(No. 410 State St.)

File No. 8534

Registered No. 180

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John E. Riordan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 19 (Day) 1871 (Year)

7. AGE: 43 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho City Ida.

10. NAME OF FATHER: John T. Riordan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Bulger

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edmund H Riordan

(Address) 1314 Rose st Boise Idaho

15. Filed 7-25 1914

M L Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914, to July 25 1914, that I last saw him alive on June 24 1914 and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obs

Peritonitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Tuberculosis Peritonitis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W S Stuber M. D.

1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: July 27 1914

20. UNDERTAKER: Schreiber & Siebenpfeiffer — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 8535
Registered No. 181

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 608 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora Fox

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 31 (Day) 1882 (Year)

7. AGE: 32 Yrs. 4 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Ed Kennison

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nina Burnham

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. A. Burr
(Address) Boise Idaho

15.
Filed 7-27 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Heart disease
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Epilepsy
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) V R E Lantz M. D.
19... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: 7/27 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

BYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 8536
Registered No. 182

1. PLACE OF DEATH.
County of Boise
City of Boise
(No. 218 Warm Springs Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Wyman Gardner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 29th (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.? 8

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise, Idaho

10. NAME OF FATHER Louis Gardner

11. BIRTHPLACE OF FATHER Ills (State or Country)

12. MAIDEN NAME OF MOTHER Grace Bowerman

13. BIRTHPLACE OF MOTHER Ind. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. J. Falconer
(Address) Boise Ida

15. Filed 7-30 1914 Mrs Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/30 1914, to 7/30 1914, that I last saw him alive on 7/30 1914, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) ..... Yrs. ..... mos. 8 Hrs.

Contributory (Secondary) .....

(Duration) ..... mos. ..... ds.

(Signed) Fred A. Ellingsen M. D.

7/30 1914 (Address) Falk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL, CREMATION OR REMOVAL: Morris Hill Cem. Boise Ida | DATE OF BURIAL: 7/31 1914

20. UNDERTAKER: Schreiber & Lieberfeld | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

5738 - YORK CO., PTRS. & RMRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 8515
Registered No. 183

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 241 Fairview Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sol W. Means.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. July (Month) 3rd (Day) 1873 (Year)
7. AGE: 41 Yrs. — Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Iowa.
10. NAME OF FATHER Thos. Means
11. BIRTHPLACE OF FATHER Penn (State or Country)
12. MAIDEN NAME OF MOTHER Lucinda Bibley
13. BIRTHPLACE OF MOTHER Ohio (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Bert Means Boise, Idaho.
15.
Filed 7 — 30 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 30 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 7/29 1914, to 7/30 1914, that I last saw h-im alive on 7/30 1914 and that death occured on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows: Angina Pectoris.
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs mos ds.
(Signed) Fred. A. Ellinger M. D.
7/30 1914 (Address) Salt Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	7/31 1914
20. UNDERTAKER Schreiber & Siddenfaden	ADDRESS Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
(No. 11 Miles S. End of Boise)

File No. 8538
Registered No. 39

1. PLACE OF DEATH.
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milton Power

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. January (Month) 1 (Day) [illegible] (Year)

7. AGE: 66 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Phillips Power

11. BIRTHPLACE OF FATHER (State or Country): Am.

12. MAIDEN NAME OF MOTHER: Wesley Bodenhamer

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Isaac Palmer
(Address) Meridian

15. Filed July 3 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ saw
~~191~~, to dead ~~191~~,
that I last saw h[illegible] alive on ~~191~~,
and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Gun shot wound
Suicide

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Adolph Schreiber M. D.
7/2 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Ida
DATE OF BURIAL: July 3 1914

20. UNDERTAKER: Schreiber & Leipheimer
ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.

Primary Registration District No.

(No. 11 Miles S. East of Boise St.)

File No. 8539

Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Malinda Gertrude Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 19 (Day) 1882 (Year)

7. AGE: 32 Yrs. ..... Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Bartemus Palmer

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Brown

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Isaac Palmer
(Address) Meridian

15. Filed 7-3 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ ~~191~~ to Date ~~191~~ ~~that I last saw him~~ alive on ~~191~~ dead, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Gun shot wound
Murder

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Adolph Schreiber M. D.

7/2 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days In the State 30 Minutes yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ada Co

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho
DATE OF BURIAL: 7/3 1914

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8540
Registered No. 3/[illegible]

1. PLACE OF DEATH.
County of Ada
City of near Boise
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Louise Atwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. July (Month) 14 (Day) 1914 (Year)
7. AGE: ....Yrs. —Mos. 6 ds. IF LESS than 1 day how many .....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Boise Idaho
10. NAME OF FATHER: Earnest Atwood
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Lula Judkin
13. BIRTHPLACE OF MOTHER (State or Country): Virginia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ernest O Atwood
(Address) RR#2
15. Filed 7-20 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 14 1914, to July 20 1914, that I last saw h[illegible] alive on July 20 1914, and that death occured on the date stated above, at 11 30 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia.
.....(Duration) .....Yrs. .....mos. 1 ds.
Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.
(Signed) J. E. Mangle M. D.
July 20 1914 (Address) Boise

(State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 21 1914
20. UNDERTAKER: Tinys Sepmmen — ADDRESS: Boise Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8542
Registered No.

1. PLACE OF DEATH. Registration District No. 57
County of Bear Lake Primary Registration District No. 2136
City of Montpelier (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mida E. Bergren

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Dec 26 1909 (Month) (Day) (Year)
7. AGE: 4 yrs. 8 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student at School
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Woodruff Bear Lake
10. NAME OF FATHER: William Bergren
11. BIRTHPLACE OF FATHER (State or Country): St Charles Idaho
12. MAIDEN NAME OF MOTHER: Mary J Simmons
13. BIRTHPLACE OF MOTHER (State or Country): Bloomington Ills
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr Geo F Cooley
(Address) Montpelier Ida
15. Filed 8/25 1914 H H Kingsley Local Register

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 25 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 23 191.. to Aug 24 1914
that I last saw h.. alive on Aug 24 1914
and that death occurred on the date stated above, at 5:45 P.M.
The CAUSE OF DEATH* was as follows: Appendicitis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo F Cooley M. D.
..... 19..... (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs. 8 mos. 3 ds. In the State 4 yrs. 8 mos. 3 ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodruff — DATE OF BURIAL: 8/26/1914
20. UNDERTAKER: None — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8543
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Potlatch.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65.
Primary Registration District No. 2145.
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Gust E Lundgren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: 6 (Month) 18 (Day) 1845 (Year)

7. AGE: 39 yrs. 2 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. G. E. Lundgren
(Address) Potlatch Idaho

15. Filed Aug 15th 1914 D. G. W. Ramsey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-27 1914, to 8-12 1914
that I last saw him alive on 8-11 1914
and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

(Duration) ..... yrs. ..... mos. 16 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. McPaul M. D.
8-13 1914 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Potlatch Idaho	Aug 16 1914

20. UNDERTAKER: E Anderson ADDRESS: Palouse Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2682
(No. ....., ... St.)

File No. 8544
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Bloomington
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nina Welker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. August (Month) Fourth (Day) 1891 (Year)
7. AGE: 23 Yrs. ——— Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Adam Welker
11. BIRTHPLACE OF FATHER (State or Country) Utah
12. MAIDEN NAME OF MOTHER Clara Osmond
13. BIRTHPLACE OF MOTHER (State or Country) Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roy A. Welker
(Address) Paris, Idaho
15. Filed Sept. 1st, 1914 R. J. Sutton Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1914, to Aug. 10 1914, that I last saw her alive on Aug 10 1914, and that death occured on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:
Progressive Bulbar Paralysis.

about
(Duration) ten Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ed. Budge Per R. J. Sutton M. D.
19..... (Address) Logan Utah.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bloomington Idaho
DATE OF BURIAL: Aug 16 1914

20. UNDERTAKER: Rose Welker
ADDRESS: Bloomington Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 8545
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 17 (Day) 1914 (Year)

7. AGE: ___ yrs. ___ mos. ___ ds.
IF LESS than 1 day how many .. 6 .. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Vernie Taylor

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Rosa Rambo.

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Verna Taylor
(Address) Twin Falls

15. Filed July 18 1914 John Bingham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1914, to July 17 1914, that I last saw h[illegible] alive on July 17 1914 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Marasmus

(Duration) ... yrs. ... mos. 6 hrs.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. W. Lynch M. D.
19 (Address) Twin Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: July 18 1914

20. UNDERTAKER: J. F. Ingraham ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of " "

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 8546

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kiyo Kato

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Brown

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 7th (Day) 1890 (Year)

7. AGE: 24 Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: S Kamaki

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: S Kamaki

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S Kato

(Address) Twin Falls Ida

15. Filed 7-21 1914 John Boyle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1914, to July 20 1914, that I last saw h[illegible] alive on July 20 1914, and that death occured on the date stated above, at 12 A M.

The CAUSE OF DEATH* was as follows:

Eclampsia

(Duration) ..... Yrs. ..... mos. 8 hrs. ds.

Contributory (Secondary) Pregnancy

(Duration ..... yrs. 4 mos. ..... ds.

(Signed) J. K. Morgan M. D.

7/30 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portland Ore. DATE OF BURIAL ..... 191...

20. UNDERTAKER: H B Evans ADDRESS Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 8547
Registered No. ____

1. PLACE OF DEATH
County of Twin Falls
City of ~~Twin Falls~~ Twin Falls Ida
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Kessler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July 26 (Month) (Day) 1914 (Year)

7. AGE ____ Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many ?... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jno D Kessler

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Nellie Whitney

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John A. Kessler
(Address) Filer Idaho.

15. Filed July 27 1914
John Longfellow
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 26 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1914, to July 26 1914, that I last saw h... alive on July 26 1914, and that death occured on the date stated above, at 3.30 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary)
(Duration ____ yrs. ____ mos. ____ ds.
(Signed) J. R. Morgan M. D.
7-27 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 7-27 1914

20. UNDERTAKER: Chas J Cosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6V30 - YORK CO., PTRS. & ENGS. 24668

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 8548
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carlile Boylan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. August (Month) 4 (Day) 1912 (Year)

7. AGE: 1 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER G. S. Boylan

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Ida Inglee

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. W. Boylan
(Address) Morris & Elizabeth Ave.

15. Filed July 25 1914 John H. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Drowning
In lateral on Ave. East, City
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Charles J. Crosby Coroner
19..... (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: July 26 1914

20. UNDERTAKER: Thos J Crosby
ADDRESS: Twin Falls

6180 - 10M-CO.-FTSB. & BARR. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 37
County of Twin Falls Primary Registration District No. 1085 File No. 8549
City of [illegible] (No. ....., ... St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Jungert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 9 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 7 ds. IF LESS than 1 day how many ..... hm. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER C A Jungert

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Vivian Hiddleson

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C A Jungert
(Address) .....

15. Filed July 16 1914 John F. Eagelin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1914, to July 16 1914, that I last saw h[illegible] alive on July 16 1914 and that death occurred on the date stated above, at 3 9 M.

The CAUSE OF DEATH* was as follows:

Obstruction.

(Duration) ..... yrs. ..... mos. 8 ds.
Contributory (Secondary) Premature birth
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F Eagelin M. D.
7/16 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida.	July 16 1914
20. UNDERTAKER	ADDRESS
T. F. Grossman	Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of 1 1 1
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ..., ... St.)

File No. 8550
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chester D. Meacham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
June (Month) 12 (Day) 1913 (Year)

7. AGE
1 yrs. 1 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Utah.

10. NAME OF FATHER Lyman Meacham

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Clara Rose

13. BIRTHPLACE OF MOTHER
(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lyman Meacham
(Address) Twin Falls

15.
Filed July 17 1914 John T. Coughlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
accidental drowning in irrigation ditch.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J. Crosby Coroner M. D.
7/17 1914 (Address) By B. Marsh Deputy, Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENCE, state: (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morgan Utah	July 19 1914

20. UNDERTAKER	ADDRESS
W. J. Grossman	Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of 4 11
Registration District No. 37
Primary Registration District No. 2085
(No. ....., ... St.)
File No. 8551
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John T. Freed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 14 (Month) (Day) 1891 (Year)

7. AGE: 23 Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School teacher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Baker Kansas

10. NAME OF FATHER J. K. Freed

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Mary L. Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. K. Freed
(Address) Scott City Kans.

15. Filed Aug 1 1914 John Eagle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. J. Crosby Coroner M. D.
19... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Scott City Kansas | DATE OF BURIAL: July 31 1914

20. UNDERTAKER: G. J. Crosby ADDRESS: Twin Falls

BYRNE - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1478
Primary Registration District No. 2453
(No. ....., ... St.)

File No. .....
Registered No. 531
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs. Mary Le Huguet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married.

6. DATE OF BIRTH
July (Month) 2 (Day) 1847 (Year)

7. AGE
66 yrs. 11 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Nicholas d.

11. BIRTHPLACE OF FATHER (State or Country) Luxemburg.

12. MAIDEN NAME OF MOTHER Tusart.

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Le Huguet
(Address) Sandpoint

15.
Filed Aug 13 1914 M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cardiac failure - found in bed as mon's as left at night -
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Aortic stenosis and asthma
..... (Duration) 5 yrs. ..... mos. ..... ds.
(Signed) M. McKinnon M. D.
July 26 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death .....yrs. .....mos. .....ds. State .....yrs. .....mos. .....ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Sandpoint Ida — DATE OF BURIAL 6/28/1914

20. UNDERTAKER E. M. Brower — ADDRESS Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Hope
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2139
(No. ....., ... St.)

File No. [illegible]
Registered No. 328
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Shipley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	White	Single (Write the word.)

6. DATE OF BIRTH
..... (Month) ..... (Day) 1860 (Year)

7. AGE
54 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER
Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER
Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Coroner W. M. McKenzie
(Address) Hope Idaho

15.
Filed Aug 9/13 1914 M. M. McKenzie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 17th or 18th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gun Shot wound
Given hand of some
Person unknown
Supposed to be Killed
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) instantly
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Coroner W. M. McKenzie M. D.
19.... (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 22 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hope Idaho | DATE OF BURIAL: June 21 1914

20. UNDERTAKER: E. M. Brewer | ADDRESS: Sand Point Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

Me

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5-21

Registered No. 525

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abinger Boughner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... 1 (Day) ..... (Year)

7. AGE: 60 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Geo. Boughner

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Elizabeth Boughner
(Address) Sandpoint

15.
Filed Aug 13 1914 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 11 1914
that I last saw him alive on June 10 1914
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Tuberculosis Pulmonary
..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.
June 12 1914 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: 6/13 1914

20. UNDERTAKER: E M Brown
ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2133
City of Sandpoint (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME George Thanos

File No. 8556
Registered No. 527
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single
6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)
7. AGE: 22 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry business, or establishment in which employed (or employer): Lumbering
9. BIRTHPLACE (State or Country): Greece
10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (State or Country): Greece
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): Greece
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Allen
(Address) Laclede
15.
Filed Aug 19 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 11 1914, to June 15 1914
that I last saw him alive on June 15 1914,
and that death occurred on the date stated above, at 9 30 P. M.
The CAUSE OF DEATH* was as follows:

Accidental steam burns.

..... (Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. A. Allen M. D.
June 16 1914 (Address) Laclede

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: E M Brower — DATE OF BURIAL: 6/17 1914
20. UNDERTAKER: Sandpoint — ADDRESS: Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNES-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2133

File No. 8557

County of Bonner

City of Hope (No. ....., ... St.)

Registered No. 329

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick J. Welch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sin

6. DATE OF BIRTH: 17 or 18 1856
(Month) (Day) (Year)

7. AGE: 58 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): unknown U.S.

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Kaney Jr
(Address) Hope Idaho

15.
Filed Aug 9 / 14 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 17th, 18th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gun Shot wound in Hand
by unknown person
Supposed to be Killed
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) instantly
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm Kaney Jr M. D.
19.... (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Hope Idaho — DATE OF BURIAL: Jun 21 1914

20. UNDERTAKER: E. M Brower — ADDRESS: Sand Point Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 330

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 78

County of Kootenai Primary Registration District No. 2153

City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Stevens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 57 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work ... Rancher
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) unknown

10. NAME OF FATHER //

11. BIRTHPLACE OF FATHER (State or Country) //

12. MAIDEN NAME OF MOTHER //

13. BIRTHPLACE OF MOTHER (State or Country) //

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Frazier

(Address) Retlaw Alta, Can.

15.

Filed Aug 13 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to June 19 1914 that I last saw him alive on June 19 1914, and that death occurred on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) 6 hours yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis - from abuse of liquor

(Duration) Several yrs. ..... mos. ..... ds.

(Signed) R. E. Jackson M. D.

June 19 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Victory Cdy | DATE OF BURIAL June 21 1914

20. UNDERTAKER E M Brower | ADDRESS C. d'A

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 18172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8559

Registered No. 538

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2133

County of Bonner

City of Sand Point (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Alfred Nichols

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 25 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry business, or establishment in which employed (or employer): Logging Camps

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E M Brown

(Address) Sand Point Ida

15.

Filed Aug 9 19 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Knapp M. D.

7/14 1914 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: 7/17 1914

20. UNDERTAKER: E M Brown — ADDRESS: S P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNES-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2103

File No. 5310

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 632

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond L Mitchell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Jan (Month) 31 (Day) 1897 (Year)

7. AGE: 17 yrs. 5 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Hunter
(b) General nature of industry business, or establishment in which employed (or employer): Dunn room Lbr Mfg Co

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: H J Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Florence O Lofton

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry G. Mitchell

(Address) 726 Pine City

15.

Filed Aug 19 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....

that I last saw h..... alive on ..... 191....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning,

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Knapp M. D.

7/13 1914 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place ..... In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was Disease contracted,

If not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: 7/14 1914

20. UNDERTAKER: C M Brown — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Boundary

Primary Registration District No. 215-3

City of Sagle

(No. ....., ... St.)

File No. .....

Registered No. 334

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ovie Berg

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH

July (Month) 20 (Day) 1914 (Year)

7. AGE

— yrs. — mos. — ds. 7 hrs

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Peter Olaf Berg

11. BIRTHPLACE OF FATHER (State or Country) Sweeden

12. MAIDEN NAME OF MOTHER Annie Blomberg

13. BIRTHPLACE OF MOTHER (State or Country) Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Berg

(Address) Sagle

15.

Filed Aug 19 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914, to June 191..., that I last saw h.im alive on July 20 1914 and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(6 mo child - a twin)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Hemorrhage from Cord

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Strackhouse M. D.

July 20 1914 (Address) Sand Point

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sagle	July 21 1914

20. UNDERTAKER	ADDRESS
Father.	Sagle.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Blanchard
(No. ....., ... St.)

Registration District No. 78
Primary Registration District No. 2153

File No. .....
Registered No. 538

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Brita Running

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 25 (Day) 1888 (Year)

7. AGE: 26 yrs. 6 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Elizabeth Wickham

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Running
(Address) Blanchard Idaho

15.
Filed Aug 13 1914 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to July 21 1914
that I last saw her alive on July 21 1914
and that death occurred on the date stated above, at 9 45 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Phthisis
about
(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle D Parish M. D.
July 22 1914 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blanchard Ida
DATE OF BURIAL: July 22 1914

20. UNDERTAKER: none
ADDRESS:
Casket sold by J. R. Kleffner undertaker Rathdrum Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated CORRECTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examination of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of

Primary Registration District No. 2153

City of

(No. , St.)

File No.

Registered No. 5-37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Murray

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH July (Month) 9 (Day) 1854 (Year)

7. AGE 60 yrs. — mos. 17 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER Christopher McKay

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF ~~MOTHER~~ Margaret McKay

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jessie Murray Sifton
(Address) Vancouver BC

15.

Filed Aug 13 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914, to July 26 1914 that I last saw her alive on July 26 1914 and that death occurred on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Diabetic Coma

..... (Duration) ..... yrs. ..... mos. 2 hours ds.

(Signed) C. P. Strachan M. D.

Aug 10 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.

In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sandpoint | DATE OF BURIAL 7/28 1914

20. UNDERTAKER E M Brown | ADDRESS Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2163
File No. 806-E
Registered No. 338

1. PLACE OF DEATH.
County of Bonner
City of Sagle (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Silvesey Berg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Single (Write the word.)

6. DATE OF BIRTH: July (Month) 20 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Peter Olaf Berg

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Annie Bloomberg

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Berg
(Address) Sagle

15. Filed Aug 13 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914, to July 28 1914, that I last saw her alive on July 20 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth
(6 mo. Child. a twin)
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Strackhouse M. D.
7/28 1914 (Address) Sand Point

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sagle | DATE OF BURIAL: July 29 1914

20. UNDERTAKER: Foster | ADDRESS: Sagle.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No. 2201
File No. 24
Registered No. 8565

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William J. Wood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. 1 (Month) 1 (Day) 1860 (Year)

7. AGE: 54 Yrs. 7 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: — — Wood.

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Rachel. Moy

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. W. J. Wood
(Address) Kellogg

15. Filed Sep 12 1914 Geo J Lesher Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1914, to ..... 191..., that I last saw him alive on Aug 29 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Landram M. D.
9/4/1914 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg
DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: Thornhill
ADDRESS: Kellogg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

(No. ....., ... St.)

File No. 23

Registered No. 5565

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Antone Conda

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): November 1 1

7. AGE: 21 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 7/29 1914

Geo J Foster
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) (Day) (Year): Aug 28 1914

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1914, to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Electrocuted.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... Yrs. ..... mos. ..... ds.

(Signed) H. L. Lambert M. D.

19.... (Address) Kellogg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Butte — DATE OF BURIAL: 8/30 1914

20. UNDERTAKER: Worstell — ADDRESS: Kellogg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 123

County of Shoshone — Primary Registration District No. 2101

City of Kellogg (No. Kellogg Hospital St.)

File No. 70

Registered No. 5[illegible]

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Thom[illegible]

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: [illegible] (Month) [illegible] (Day) 1869 (Year)

7. AGE: 45 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): Lead Mine

9. BIRTHPLACE (State or Country): No information

10. NAME OF FATHER: No information

11. BIRTHPLACE OF FATHER (State or Country): No information

12. MAIDEN NAME OF MOTHER: No information

13. BIRTHPLACE OF MOTHER (State or Country): No information

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Barton
(Address) Kellogg, Ida.

15. Filed 8/7 1914 Geo. S. Leeber Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 6th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 3 1914, to August 6 1914, that I last saw him alive on August 5 1914, and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows: (Contusion
Mine accident - Pneumonia and peritonitis following injuries to chest and abdomen

(Duration) ... yrs. ... mos. 3 ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Alex. D. McCracken M. D.

Aug 6 1914 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 3 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Alexandria Mine — DATE OF BURIAL: Aug 6 1914

20. UNDERTAKER: Bruce & Woodall — ADDRESS: Wallace Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201
(No. Stewart Mine St.)

File No. 74
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Meyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	single

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1912 (Year)

7. AGE: 1 yrs. 11 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph A. Meyer

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Cecilia Kangeary

13. BIRTHPLACE OF MOTHER (State or Country) Austria Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph A Meyer
(Address) Kellogg Idaho.

15.
Filed 8/7 1914 Geo. D Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1914, to Aug 6 1914, that I last saw him alive on Aug 6 1914, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:
Acute Enteritis
(Cholera Infantum)

(Duration) yrs. mos. 15 ds.

Contributory (Secondary) —
(Duration) yrs. mos. ds.

(Signed) Alex. D. McCracken M. D.
Aug 7 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Maries Ida — DATE OF BURIAL: Aug 6 1914

20. UNDERTAKER: Bruce G. Wonstel — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Kellogg.

Registration District No. 123

Primary Registration District No. 7701

(No. ..... St.)

File No. 19

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pauline Mason Talbot

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. May (Month) 23 (Day) 1891 (Year)

7. AGE: 23 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): California.

10. NAME OF FATHER: Peter Mason.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Florence Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Cal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Peter Mason

(Address) Kellogg Idaho

15. Filed 8/15 1914 Geo. S Lasher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1914, to Aug 1st 1914, that I last saw her alive on July 31 1914, and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Lindsay M. D.

Aug 2 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho. DATE OF BURIAL: 8/15 1914

20. UNDERTAKER: Stonehill. ADDRESS: Kellogg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGR. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wardner.
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 120
Primary Registration District No. 7201
(No. ....., ... St.)

File No. 22
Registered No. 5210

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Rowena Erwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Apr (Day) 7 (Year) 1913

7. AGE: 1 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Wm David Erwin

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Anna Laura Parkwood

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. D. Erwin
(Address) Wardner

15. Filed Nov 1 1914 Geo. L. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) Aug (Day) 18 1914

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1914, to ..... 191..., that I last saw h[illegible] alive on Aug 18 1914, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Gastro-enteritis / toxic exhaustion
Convulsions

(Duration) 1 Yrs. mos. 14 ds.
Contributory (Secondary) Whooping Cough
(Duration ... yrs. ... mos. ... ds.

(Signed) H. L. Lindsay M. D.
1914 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Ida.
DATE OF BURIAL: 8/20 1914

20. UNDERTAKER: Morstedt
ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 2119

City of Preston (No. ....., ... St.)

File No. .....

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Carlson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1914 (Year)

7. AGE: X yrs. 7 mos. 18 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Preston

10. NAME OF FATHER: Einer Carlson

11. BIRTHPLACE OF FATHER (State or Country) Copenhagen

12. MAIDEN NAME OF MOTHER: Mari Erickson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Einer Carlson
(Address) Preston

15.
Filed Sept 2 1914 Dr Allen R Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1914, to Sept 1 1914, that I last saw h[im] alive on Sept 1 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ✓ yrs. ✓ mos. 20 ds.

Contributory (Secondary) Intestinitis

(Duration) ✓ yrs. 2 mos. ✓ ds.

(Signed) Geo W Gates M. D.

Sept 2 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Cemetary	Sept 2 1914
20. UNDERTAKER	**ADDRESS**
W A Skidmore	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Weston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 9119
(No. ....., ... St.)

File No. 8572
Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Neils Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH: Jan (Month) 14 (Day) 1833 (Year)

7. AGE: 81 yrs. 8 mos. 1 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Olef Christensen
(Address) Weston

15. Filed Aug 20 1914 — Wm. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9th 1914, to Aug 14 1914
that I last saw him alive on Aug 12 1914
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. W. Druck M. D.
19 .... (Address) Weston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weston Ida — DATE OF BURIAL: Aug 16 1914

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. .....
Registered No. .....

1. PLACE OF DEATH.
County of Franklin
City of Weston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Poburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 20 (Day) 1852 (Year)

7. AGE: 62 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Christen Jensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Emma Jensen

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jos Poburn Jr.
(Address) Weston Ida

15.
Filed .....191....
R. O. Leich
Local Registrar
W. Allen Curtis

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21st 1914, to Aug 12th 1914, that I last saw h[er] alive on Aug 12th 1914, and that death occured on the date stated above, at 4 a. M.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.
(Signed) R. O. Leich M. D.
19.... (Address) Weston, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston, Ida — DATE OF BURIAL: Aug 13 1914

20. UNDERTAKER: C. J. Hansen — ADDRESS: Preston Ida

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration Di[redacted] 27
County of Franklin Primary Regis[redacted]ct No. 2119
City of Riverdale (No. [redacted] St.)
File No.
Registered No. 37

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Fe[redacted]ndo N Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTIC[redacted]

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	Single

6. DATE OF BIRTH August (Month) 12 (Day) 1895 (Year)

7. AGE 19 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Riverdale Idaho

10. NAME OF FATHER H. J. Smith

11. BIRTHPLACE OF FATHER (State or Country) ~~Iowa~~ Iowa

12. MAIDEN NAME OF MOTHER Elvira Walker

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H J Smith
(Address) Riverdale Idaho

15.
Filed Aug. 15 1914 D Allen Quilter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug. (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —— 191[redacted], to One week 191[redacted]
that I last saw him alive on —— 191[redacted]
and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Duodenal ulcer - hemorrhage with perforation - (Valvular disease of heart)
(Duration) [redacted] yrs. — mos. — ds.
Contributory (Secondary) Chronic simple obstruction of bowels - Carbon Monoxide gas poisoning
(Duration) 8 hrs — yrs. — mos. — ds.
(Signed) D Allen Quilter M. D.
19 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Riverdale — DATE OF BURIAL Aug 14 1914

20. UNDERTAKER H. A. Skidmore — ADDRESS Per H. A. Skidmore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 1018
Registered No. 38
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Benson Roper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married

6. DATE OF BIRTH
Aug. (Month) 1 (Day) 1858 (Year)

7. AGE
55 yrs. 11 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farming
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lehi Ut

10. NAME OF FATHER Jos B Roper

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Hannah E Nolen

13. BIRTHPLACE OF MOTHER (State or Country) Un Brown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia Roper
(Address) Preston Idaho

15.
Filed Aug. 20 1914 D. William Ruben
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to July 21 1914, that I last saw h in alive on July 21 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy
..... (Duration) ..... yrs. 2 mos. 20 ds.
Contributory (Secondary) none
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr. H. Caudell M. D.
July 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: July 23 1914

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Franklin
City of Dayton
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 5011
Registered No. 40
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Boaden

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: April 21 1883 (Month) (Day) (Year)
7. AGE: 31 yrs. 3 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Battle Creek Ida.
10. NAME OF FATHER: Willard Boden
11. BIRTHPLACE OF FATHER (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Dicey B. Wakley
13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willard Boden
(Address) Dayton Idaho.
15.
Filed Sept 2 1914 W. A. Meyers Coroner
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July 23rd, 1914 191....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suicide by hanging, brought on by financial troubles and temporary insanity.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Meyers Coroner ..... M. D.
19.... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dayton, Idaho.
DATE OF BURIAL: July 24 191 4

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston, Ida.

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Franklin

Primary Registration District No. 2119

File No.

City of Preston (No. ....., ... St.)

Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie Ann Tippetts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Married

6. DATE OF BIRTH: August (Month) 29 (Day) 1887 (Year)

7. AGE: 26 yrs. 11 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Morgan Utah

10. NAME OF FATHER: Joseph J. Waldrom

11. BIRTHPLACE OF FATHER (State or Country): Centerville Ut. Clarkston Utah

12. MAIDEN NAME OF MOTHER: Maryette Rich

13. BIRTHPLACE OF MOTHER (State or Country): Richfield Morgan Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Abbott
(Address)

15.
Filed Aug 15 1914 Dr Ellen P Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1914, to Aug 7 1914, that I last saw h[illegible] alive on Aug 7 1914, and that death occurred on the date stated above, at 3.25 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia and Shock following Childbirth

(Duration) 0 yrs. 0 mos. 4 hours ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W Gates M. D.

Aug 8 1914 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston

DATE OF BURIAL: Aug 9 1914

20. UNDERTAKER: W A Skidmore

ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2119
File No. [illegible]
Registered No. 96

1. PLACE OF DEATH.
County of Franklin
City of Mink Creek (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans Christen Hansen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Jan. (Month) 2 (Day) 1854 (Year)

7. AGE: 60 yrs. 7 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark Fein

10. NAME OF FATHER: Hans Hansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark Fein

12. MAIDEN NAME OF MOTHER: Abalona Christensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark Fein

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christen Hansen
(Address) Route Logen Utah

15.
Filed Aug 15 1914 Dr Allen Rallis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1914, to Aug 14 1914, that I last saw him alive on Aug. 8th 1914, and that death occurred on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis.
abscess
(Duration) ..... yrs. 1 mos. 15 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen Rallis M. D.
19 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mink Creek
DATE OF BURIAL: Aug. 16 1914

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 8580
Registered No. 41
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Esther D. Hardy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: March (Month) 16 (Day) 1836 (Year)

7. AGE: 78 yrs. 5 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Massachusets.

10. NAME OF FATHER Benjamin Goodrich

11. BIRTHPLACE OF FATHER (State or Country) Massachusetts.

12. MAIDEN NAME OF MOTHER Penelope R Gardner

13. BIRTHPLACE OF MOTHER (State or Country) Massachusetts

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rhoda A Garn.
(Address) 1898 S 9 East Salt Lake City

15.
Filed Sept 2 1914 D. Allen Rulle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1914, to Aug. 29 1914 that I last saw her alive on Aug 29 1914, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Lagrippe.

(Duration) ..... yrs. 1 mos. 4 ds.
Contributory (Secondary) Senile decay
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen R Rulle M. D.
19 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City — DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: W. A. Shadmore — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Noel Cheney

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
March (Month) 7 (Day) 1914 (Year)

7. AGE
— Yrs. 5 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER: Franklin James Cheney

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER: Beatrice Barnes

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Franklin J. Cheney
(Address) Burley Idaho

15.
Filed Aug. 30 1914
Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1914, to aug 30 1914, that I last saw h[illegible] alive on aug 30 1914, and that death occured on the date stated above, at 17 M.

The CAUSE OF DEATH* was as follows:
Cholorea Infantum
.....
.....
(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John M Minter M. D.
Aug 30 1914 (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Raysville Idaho — DATE OF BURIAL: Sept 1 1914

20. UNDERTAKER: A L Watt — ADDRESS: Burley

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No.
(No. , St.)
File No. 5339
Registered No. 36

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vernon Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 13 (Day) 1913 (Year)

7. AGE: 1 Yrs. 6 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas Magnus Olson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Grace Grausbury

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles M. Olson
(Address) Burley Idaho

15.
Filed Aug. 29 1914
Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 29 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 20 1914, to Aug. 29 1914, that I last saw h[illegible] alive on Aug. 28 1914, and that death occured on the date stated above, at 5P. M.

The CAUSE OF DEATH* was as follows:
Ileo - Colitis

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) J. C. Patterson M. D.
8-29 1914 (Address) Dr. J. C. Patterson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: DATE OF BURIAL Aug 30 1914

20. UNDERTAKER: A L Watt ADDRESS Burley

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. [illegible]
Registered No. 22

1. PLACE OF DEATH.
County of Elmore
City of Mountainhome (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel N Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
January (Month) 2 (Day) 1835 (Year)

7. AGE
79 yrs. 7 mos. 3 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mass

10. NAME OF FATHER Nathaniel N. Pierce

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER Sarah —

13. BIRTHPLACE OF MOTHER (State or Country) Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lyman M. Pierce
(Address) Table

15.
Filed ..... 191... Clerk.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1914, to Aug 4 1914, that I last saw him alive on Aug 4 1914, and that death occurred on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:
Uremia

(Duration) ..... yrs. ..... mos. 16 ds.
Contributory (Secondary) Chronic nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L Hawley M. D.
Aug 6 1914 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Mountainhome | DATE OF BURIAL Aug 8th 1914

20. UNDERTAKER J M Cowen | ADDRESS Mtn home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 8583

Name Saurel N. Pierce

Date of Death Aug. 5, 1914.

Cause of Death Uremia

Contributary Cause of death Chronic Nephritis

(Sign here) F. A. Hawley M.D.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of Burley
(No. ....., ... St.)

Registration District No. 34
Primary Registration District No. 2087

File No. 858
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maude Evelyn Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1911 (Year)

7. AGE: 3 Yrs. 5 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Ed Johnson

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Hattie V Drummond

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ed Johnson
(Address) .....

15. Filed Aug 7 1914
J. T. Wilson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914, to Aug 1 1914, that I last saw her alive on Aug 1 1914, and that death occured on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Enteritis colitis
18 hours.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas. Wilhelm M. D.
19..... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley — DATE OF BURIAL: Aug 2 1914

20. UNDERTAKER: H B Evans — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 5755
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burke
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ~~Stillborn~~ Male

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 14 (Day) 14 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 5 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... X
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burke

10. NAME OF FATHER W. C. Downs

11. BIRTHPLACE OF FATHER (State or Country) Mitchell Ind

12. MAIDEN NAME OF MOTHER Flora Duncan

13. BIRTHPLACE OF MOTHER (State or Country) Manly Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. C. Downs
(Address) Burke Ida

15.
Filed J. 15 1914
J. H. Murphy
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1914, to Aug 14 1914, that I last saw h[er] alive on Aug 14 1914, and that death occured on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murphy M. D.
J. 15 1914. (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke Ida — DATE OF BURIAL: Aug 15 191[4]

20. UNDERTAKER: H. B. Evans — ADDRESS: Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary H Wyrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 1 [illegible] 1840 (Month) (Day) (Year)

7. AGE: 74 yrs. 2 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house keper
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Washington Williams

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Rude

13. BIRTHPLACE OF MOTHER (State or Country): East Prow

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Behara C Mattot
(Address) Grangeville

15.
Filed 8/26 1914 W.F. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10th 1913, to 8/26 1914
that I last saw her alive on same 1914
and that death occurred on the date stated above, at 9:30 A M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

..... (Duration) 1½ yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.F. McMahan M. D.
8/26 1914 (Address) Kamiah Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Winona, Idaho.
DATE OF BURIAL: 8/27 1914

20. UNDERTAKER: S. W. Patterson
ADDRESS: Winona

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
(No. ..... St.)
File No. .....
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles C. Wieder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept 8. 1872 (Month) (Day) (Year)

7. AGE: 41 - 11 - 13 ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Carthage Illinois

10. NAME OF FATHER: Alonzo Wieder

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah L Scott

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah L. Wieder
(Address) Grangeville Idaho

15.
Filed Sept 1 1914 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1914 to Aug 21 1914
that I last saw h~~e~~r alive on aug 21 1914
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Don't Know yrs. ..... mos. ..... ds.
Contributory (Secondary) Valvular heart disease
(Duration) Don't Know yrs. ..... mos. ..... ds.
(Signed) G B Stockton M. D.
aug 21 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: aug 23 1914

20. UNDERTAKER: W E Graham | ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1051
File No. [illegible]
Registered No. 32

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Aileen D. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 30 1876 (Month) (Day) (Year)

7. AGE: 38 yrs. 1 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wife of H.A. Anderson
(b) General nature of industry, business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oakland California

10. NAME OF FATHER: A.D. Greene

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Olive Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Columbus Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Anderson
(Address) Grangeville Idaho

15. Filed Sept 1 1914 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 24 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1914 to Aug 24 1914 that I last saw h[illegible] alive on Aug 24 1914 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows: Acute from Intestinal Obstruction

(Duration) about two hours

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G B Stockton M. D.
Aug 24 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Aug 23 1914

20. UNDERTAKER: W E Graham
ADDRESS: Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103

Primary Registration District No. 2181

(No. ....., ... St.)

File No. 30

Registered No. 30

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Henry Robbins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Single

6. DATE OF BIRTH

August (Month) 4 (Day) 1852 (Year)

7. AGE

62 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kintucka

10. NAME OF FATHER Adam Robbins

11. BIRTHPLACE OF FATHER (State or Country) dont Known

12. MAIDEN NAME OF MOTHER Mary Shepherd

13. BIRTHPLACE OF MOTHER (State or Country) not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Worden East

(Address) Grangeville Ida

15.

Filed Sept 1 1914 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

aug (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to Aug 4 1914

that I last saw h.m alive on aug 1 1914

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Volvular disease of heart

(Duration) dont Know yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Idaho	aug 5 1914
20. UNDERTAKER	**ADDRESS**
W E Graham	Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. , St.)

File No. 578
Registered No. 48
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Mamie Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Feb 18th 1850
(Month) Feb (Day) 18 (Year) 1

7. AGE: 64 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Joe

10. NAME OF FATHER: Daniel M Taster

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Nancy J Harriman

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mamie Jackson. Daughter of above
(Address) Salmon City, Ida

15.
Filed August 16 1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 15th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1913, to Aug 15th 1914, that I last saw her alive on Aug 15 1914, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
Dropsy
(Duration) Last year yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) F S Wright M. D.
Aug 17 1914 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: Aug 16" 1914

20. UNDERTAKER: Mann
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 593

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

(No. ....., ... St.)

Registration District No. #1

Primary Registration District No. 2116

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March 27th 1860 (Month) (Day) (Year)

7. AGE: 54 yrs. 5 mos. 2 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER William John Brown

11. BIRTHPLACE OF FATHER (State or Country) Nova Scotia

12. MAIDEN NAME OF MOTHER Margret McDonald

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank J. Brown
(Address) Salmon

15. Filed August 31 1914 Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 29 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1913, to Aug 29 1914 that I last saw h alive on Aug 29 1914 and that death occurred on the date stated above, at PM.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

about (Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Hanna M. D.

19 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery | DATE OF BURIAL: 8-31 1914

20. UNDERTAKER: W C Doebler | ADDRESS: Salmon Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8593

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 22

Primary Registration District No. 2049

County of Kootenai

City of ~~Idaho~~ Plummer No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Julian Danskin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. January (Month) 28. (Day) 1914 (Year)

7. AGE: ..... Yrs. 7 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): near Plummer Kootenai Co. Idaho

10. NAME OF FATHER: Ralph A. Danskin

11. BIRTHPLACE OF FATHER (State or Country): State of Iowa

12. MAIDEN NAME OF MOTHER: Annie D. Lowe

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph A Danskin

(Address) Plummer Idaho

15. Filed Sept [illegible] 1914 W. L. Mickelsen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 7 1914, to Sept 8 1914, that I last saw him alive on Sept 8 1914, and that death occured on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

..... (Duration) ..... Yrs. ..... mos. [illegible] ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Carlisle M. D.

9/9 1914 (Address) Plummer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer, Ida — DATE OF BURIAL: Sept. 9th 1914

20. UNDERTAKER: W. L. Mickelsen — ADDRESS: Plummer

SYMS - YORK CO., PTRS. & BOKS. 24853

U. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 8594
Registered No. ____

1. PLACE OF DEATH.
County of Kootenai
City of Plummer
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold Raymond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July 7th 1914
(Month) (Day) (Year)

7. AGE: Yrs. ____ Mos. Two Ds. ____
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Plummer Idaho

10. NAME OF FATHER Leonard F. Raymond

11. BIRTHPLACE OF FATHER (State or Country) Helena Mont.

12. MAIDEN NAME OF MOTHER May Walker

13. BIRTHPLACE OF MOTHER (State or Country) New Hartford Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mae Raymond
(Address) Plummer Ida.

15. Filed Sept 11 1914 W. L. Markley Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1914, to ____ 191__, that I last saw him alive on ____ 191__, and that death occured on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) C. H. Carlisle M. D.
1914 (Address) Plummer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Plummer Ida. DATE OF BURIAL: July 9 1914

20. UNDERTAKER: H. H. Brickey ADDRESS: Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. .... St.)
File No. 595
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Near St. Maries
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alta Jean Saunders

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March (Month) Twelveth (Day) 1913 (Year)

7. AGE: Years 1 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Cherry Creek Idaho

10. NAME OF FATHER A. J. Saunders

11. BIRTHPLACE OF FATHER (State or Country) Big Bend W. Va

12. MAIDEN NAME OF MOTHER Maggie D. Morris

13. BIRTHPLACE OF MOTHER (State or Country) St Marys W. Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. J. Saunders
(Address) .....

15. Filed Sept. 2 1914 H. L. Mulcahy Local Registrar

SYMS - YORK CO. PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1914 to Sept 1 1914, that I last saw h. alive on Aug 31 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) H. L. Mulcahy M. D.
Sept 2 1914 (Address) St. Maries Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Maries — DATE OF BURIAL: Sept. 2 1914

20. UNDERTAKER: H. L. Mulcahy — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St. Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 8396
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles A. Saunders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct. - 22 - 1910 (Month) (Day) (Year)

7. AGE: 3 Yrs. 10 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Maries Idaho

10. NAME OF FATHER A. J. Saunders

11. BIRTHPLACE OF FATHER (State or Country) Big Bend W. Va.

12. MAIDEN NAME OF MOTHER Maggie D. Harris

13. BIRTHPLACE OF MOTHER (State or Country) St Maries Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. J. Saunders
(Address) St Maries Idaho

15. Filed Sept. 5 1914 W. L. Mudeaby Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Sept. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1914, to Sept 4 1914, that I last saw him alive on Sept 3 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pleo-colitis

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. L. Cornwall M. D.
Sept 5 1914 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Sept 5 1914

20. UNDERTAKER: W. L. Mudeaby — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Fernwood

(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

File No. 5797

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jas. Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 37 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: worked in Lumber camp

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Hendrix

(Address) Fernwood Idaho

15. Filed Aug 2 1914 H. H. Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h...alive on ..... 191..., and that death occured on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows: Blood Poisoning Ind., was heavy Booze.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Shepherd Coroner M. D.

19..... (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries, Ida. DATE OF BURIAL: Aug 4 1914

20. UNDERTAKER: H. H. Mulcahy ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

File No. 594

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. L. Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 21 (Day) 1895 (Year)

7. AGE: 19 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House keeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Fred Parker

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Senia Maton

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Parker

(Address) St. Maries

15. Filed Aug 18 1914 N. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1914, to Aug 17 1914, that I last saw her alive on " " 1914 and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Anemia followed by General Cancerous

(Duration) 3 Yrs. ... mos. ... ds.

Contributory (Secondary) Anemia

(Duration 4 yrs. ... mos. ... ds.

(Signed) Owen D. Platt M. D.

Aug 17 1914 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene | DATE OF BURIAL ..... 191...

20. UNDERTAKER: H. L. Mulcahy | ADDRESS St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. (5790)
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. P. Sandy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 30 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Working in logging
(b) General nature of industry, business, or establishment in which employed (or employer): Camp

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. L. Mulcahy
(Address) St Maries

15. Filed Aug 22 1914 W. L. Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1914, to Aug 22 1914, that I last saw h[illegible] alive on " " 1914, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Hemorrage of bowels
..... (Duration) ..... Yrs. ..... mos. 2 hr ds.
Contributory (Secondary) Dysentery
..... (Duration ..... yrs. ..... mos. 10 ds.

(Signed) Owen D Pratt M. D.
Aug 24 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rochester N. Y. | DATE OF BURIAL 1914

20. UNDERTAKER: W L Mulcahy | ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Joe
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 8500
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Hayer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Feb. (Month) 26 (Day) 1865 (Year)

7. AGE 49 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Edgerman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada Ellens

10. NAME OF FATHER Marmaduke Hayer

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER M. Hayer

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. H. Hayer
(Address) Chicago, Ill

15. Filed Aug 24 1914 N. L. Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1914, to Aug 22 1914, that I last saw h[illegible] alive on ..... 1914, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
By having a stick
driven into the left side
from an edging machine
(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Leete M. D.
8/22 1914 (Address) St Joe Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Leave, Idaho — DATE OF BURIAL Aug 25 1914

20. UNDERTAKER N. L. Mulcahy — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 8601
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hella Lebo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 25 (Day) 1889 (Year)

7. AGE: 24 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Grayson Snyder

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. Le. Lebo
(Address) St. Maries

15. Filed Aug 26 1914 N. Le. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1914, to Aug 25 1914, that I last saw her alive on Aug 25 1914, and that death occured on the date stated above, at 5:35 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia

..... (Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) Tuberculosis

..... (Duration) 1 yrs. 6 mos. — ds.

(Signed) C. Kinsolving M. D.

Aug 26 1914. (Address) St Maries, Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Stuart Iowa
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: N Le Mulcahy
ADDRESS: St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 2001
File No. 1
Registered No. 12

1. PLACE OF DEATH.
County of Ada
City of Star Idaho (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Jane Caylor Buckmaster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr Hill Indiana 1827
(Month) (Day) (Year)

7. AGE: 87 yrs. 1 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Danpill Hendrix Co Indiana

10. NAME OF FATHER: John Peter Cher Caylor

11. BIRTHPLACE OF FATHER (State or Country): not Known

12. MAIDEN NAME OF MOTHER: Rachell Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Nettie Buckmaster
(Address) Star, Idaho.

15. Filed June 1 1914 Al Hall, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 31 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from one year 191..., to May 31 1914, that I last saw her alive on May 31 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... yrs. ..... mos. 7 hrs.
Contributory (Secondary) Asthma
(Duration) Many yrs. ..... mos. ..... ds.
(Signed) Al Hall M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary — DATE OF BURIAL: June 1 1914

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

Primary Registration District No. 7001

File No. 5403

County of Ada.

City of Star. (No. ....., ... St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hannah Todd.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Aug. 10th (Month) (Day) 1831 (Year)

7. AGE: 82 yrs. 8 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Simonburn Northumberland England

10. NAME OF FATHER: Peter Lillespair

11. BIRTHPLACE OF FATHER (State or Country): Lincolnshire England

12. MAIDEN NAME OF MOTHER: Isabela Davison

13. BIRTHPLACE OF MOTHER (State or Country): Elsdon Northumberland England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Bennett
(Address) Star.

15. Filed Aug 11 1914 A.W. Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1914, to May 31 1914, that I last saw her alive on Mar 1914 and that death occurred on the date stated above, at 5.45 M.

The CAUSE OF DEATH* was as follows:
Asthma & old age

(Duration) 4 yrs. mos. ds.

Contributory (Secondary) None
Coronal

(Duration) yrs. mos. ds.

(Signed) A.W. Hall M. D.

19 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary | DATE OF BURIAL: June 1914

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Star
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 7001
(No. ....., ... St.)

File No. 1604
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances M Leuddy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: June 10 (Month) (Day) 1839 ~~1844~~ (Year)

7. AGE: 75 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Old Virginia

10. NAME OF FATHER Dont Now

11. BIRTHPLACE OF FATHER (State or Country) Dont Now

12. MAIDEN NAME OF MOTHER Dont Now

13. BIRTHPLACE OF MOTHER (State or Country) Dont Now

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Leuddy
(Address) Middleton

15. Filed June 11 1914 Ed Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Old Age Dont know
No Physician

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: June 11 1914

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 2001
File No. 18
Registered No. 11

1. PLACE OF DEATH.
County of Ada
City of Star
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Clarke Baldwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 18 (Day) 1914 (Year)

7. AGE: ___ yrs. ___ mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: none.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Star, Ada Co, Idaho

10. NAME OF FATHER: Clarke M. Baldwin

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Liddie Foster Beck

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lydia Baldwin,
(Address) Star Idaho

15. Filed July 13 1914 Ole Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1914, to July 12 1914, that I last saw h[illegible] alive on July 6 1914, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Unknown

(Duration) ___ yrs. ___ mos. 11 ds.
Contributory (Secondary) Rupture of bowel
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Ole Hall M. D.
July 13 1914 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary
DATE OF BURIAL: July 14th

20. UNDERTAKER: [illegible]
ADDRESS: Star Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Star
(No. ....., ... St.)
Registration District No. 10
Primary Registration District No. 2001
File No. 1560
Registered No. 10
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A Rudisill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Dec (Month) 13 (Day) 1841 (Year)
7. AGE: 72 Yrs. 8 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: Prosper Bennett
11. BIRTHPLACE OF FATHER (State or Country): Mass
12. MAIDEN NAME OF MOTHER: Not Obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J P Rudisill
(Address) Star Ida
15. Filed Sept 1 1914 Old Hall Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1914 to Aug 31 1914
that I last saw her alive on Aug 29 1914
and that death occured on the date stated above, at 7.10 P M.
The CAUSE OF DEATH* was as follows:
Aortic + Mitral regurgitation
(Duration) 3 Yrs. 7 mos. ds.
Contributory (Secondary) General Dropsy
(Duration) Yrs. 8 mos. ds.
(Signed) Old Hall M. D.
1914 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 1, 1914
20. UNDERTAKER: Terry & Summers — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 2001
(No. ____, ____ St.)

File No. 1
Registered No. 9
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Beatrice Mabel Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 10 (Day) 1914 (Year)

7. AGE: ____ yrs. ____ mos. ____ ds.
IF LESS than 1 day how many... 6 hrs. or ____ min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida. Leader Station

10. NAME OF FATHER: Fred H. Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Katie Myers

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred H. Mitchell
(Address): Eagle R F D No 1

15. Filed June 11 1914 O. O. Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to June 10 1914, that I last saw her alive on June 10 1914, and that death occurred on the date stated above, at 10:30 P M.

The CAUSE OF DEATH* was as follows:
Unknown
6 hours ~~old~~ only

____ (Duration) ____ yrs. 5 mos. 5 ds.
Contributory (Secondary): don't know
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) O. O. Hall M. D.
June 11 1914 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs ____ mos ____ ds. In the State ____ yrs ____ mos ____ ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery
DATE OF BURIAL: June 11 1914

20. UNDERTAKER: Myers & Summers
ADDRESS: Boise

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Star Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No.
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Washington Woodard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: January (Month) 16 (Day) 1834 (Year)

7. AGE: 80 yrs. 6 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Alfred M. Woodard

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Evelina Augusta Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. T. Woodard
(Address) Caldwell

15. Filed Aug 27 1914 A. W. Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to Aug 27 1914, that I last saw h[illegible] alive on Aug 26 1914 and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Cancer "Neck"

(Duration) yrs. 8 mos. ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) A. W. Hall M. D.

19 (Address) Star Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death [illegible] yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: Aug 28 1914

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6019

Registration District No.

Primary Registration District No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Star Idaho (No. , St.)

2. FULL NAME Eveline Woodard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May 17 (Month) (Day) 1914 (Year)

7. AGE: 80 yrs. 9 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Yarmouth Novascosia

10. NAME OF FATHER: David Robins

11. BIRTHPLACE OF FATHER (State or Country): Novascosia

12. MAIDEN NAME OF MOTHER: Snell

13. BIRTHPLACE OF MOTHER (State or Country): Novascosia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George W Woodard
(Address) Caldwell

15. Filed May 18 1914 Ew Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1914, to May 17 1914 that I last saw h[illegible] alive on 17 of May 1914 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 7 ds.

Contributory (Secondary) Fracture of Hip

(Duration) yrs. mos. 7 ds.

(Signed) Ew Hall M. D.

19 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary — DATE OF BURIAL: May 18 1914

20. UNDERTAKER: Frye & Funeers — ADDRESS: Star Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 550

Registered No. 589

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153

2. FULL NAME Mary Coolidge

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Oct 27 1895
(Month) (Day) (Year)

7. AGE: 19 yrs. 5 mos. - ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Student
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Whitney, County -

10. NAME OF FATHER: Alfred Coolidge

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Emma Scribs

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Coolidge
(Address) Lewiston Nez

15.
Filed Sept 9 1914 M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Acid Drowning

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W M Knapp M. D.
Aug 16 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cedar Grove
DATE OF BURIAL ..... 191...

20. UNDERTAKER: E M Brown
ADDRESS: S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 12½M 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sand Point
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

File No. [illegible]
Registered No. 541
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Elsie Rondda Piatt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 20 (Day) 1884 (Year)

7. AGE: 30 yrs. 11 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Reed

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Sansom

13. BIRTHPLACE OF MOTHER (State or Country): West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Piatt
(Address) Sand Point Ida

15. Filed Sept 9 1914 — W. M. McKinnon, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1914, to Aug 7 1914
that I last saw h er alive on Aug 1914
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
Tubercular enteritis

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. McKinnon M. D.
Aug 8 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Sand Point Ida

19. PLACE OF BURIAL OR REMOVAL: Sand Point Ida
DATE OF BURIAL: Aug 9 1914

20. UNDERTAKER: E. M. Brower
ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. 542

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Arthur Courser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 6 (Day) 1893 (Year)

7. AGE: 21 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): Teamster in Woods

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Avon Courser

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Amelia Caza

13. BIRTHPLACE OF MOTHER (State or Country): Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Avon Courser
(Address) Plains Mont.

15. Filed Sept 9 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Struck in head by falling tree.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Knapp M. D.
Aug 11 1914 (Address) Hope Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plains Mont — DATE OF BURIAL: 8/11 1914

20. UNDERTAKER: E M Brower — ADDRESS: Sp.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. 543

1. PLACE OF DEATH. Registration District No. 78

County of Bonner Primary Registration District No. 2153

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown Man

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M Brown

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 30 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Unknown
(b) General nature of industry business or establishment in which employed (or employer): Do

9. BIRTHPLACE (State or Country): Do

10. NAME OF FATHER: Do

11. BIRTHPLACE OF FATHER (State or Country): Do

12. MAIDEN NAME OF MOTHER: Do

13. BIRTHPLACE OF MOTHER (State or Country): Do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Brown
(Address) Sandpoint

15. Filed Sept 9 1914 W McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Exhaustion, following Debauch
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Probably Tuberculosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H W Knapp M. D.
8/16 1914 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint DATE OF BURIAL: 8/19 1914

20. UNDERTAKER: E M Brown ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of (Sandpoint)

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

File No. 5011
Registered No. 544

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown Man.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE: Unknown ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Do
(b) General nature of industry business or establishment in which employed (or employer): Do

9. BIRTHPLACE (State or Country): Do

10. NAME OF FATHER: Do

11. BIRTHPLACE OF FATHER (State or Country): Do

12. MAIDEN NAME OF MOTHER: Do

13. BIRTHPLACE OF MOTHER (State or Country): Do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Brown
(Address) Sandpoint

15. Filed 8 Sept 1914
M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Unknown ..... 191....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191...., to ..... 191....
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning (Floater)

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Thos W Knopf M. D.
8/31 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: 8/31 1914

20. UNDERTAKER: E W Brown
ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH 2447

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. Fremont Madison

Primary Registration District No. Precinct 67

File No. 1916

County of Latah

City of Avon P#1. (No. ....., ... St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Augustus Astell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: November Sixth (Month) (Day) 1835 (Year)

7. AGE: 78 yrs. 7 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer.

9. BIRTHPLACE (State or Country) Massachusetts.

10. NAME OF FATHER Daniel Astell.

11. BIRTHPLACE OF FATHER (State or Country) Massachusetts.

12. MAIDEN NAME OF MOTHER Betsy Snell

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary F. Astell
(Address) Avon Idaho.

15. Filed 8/5 1914 P. C. Hanson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1914, to Aug 4 1914, that I last saw him alive on Aug 3 1914, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

dysentery

(Duration) 0 yrs. 0 mos. 14 ds.

Contributory (Secondary) senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. C. Hanson M. D.

8/5 1914 (Address) P. C. Hanson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF ~~BURIAL OR~~ REMOVAL	DATE OF BURIAL
Palouse Wash	Aug 5 1914

20. UNDERTAKER	ADDRESS
E Anderson	Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 217
File No. 8617
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene Adolph Murri

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug 20 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Anthony

10. NAME OF FATHER: Godfred Murri

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Christena Miller

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gottfred Murri
(Address) St Anthony Idaho

15.
Filed Aug 29 1914 W. B. Wert
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug 28 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1914, to Aug 28 1914, that I last saw him alive on Aug 28 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Premature delivery
Icterus Neonatorum

(Duration) ..... yrs. ..... mos. 9 ds.
Contributory (Secondary) Premature delivery
(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) C. W. Mansfield M. D.
8/25 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford Idaho
DATE OF BURIAL: Aug 30 1914

20. UNDERTAKER: Mace
ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of Sugar

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

File No. 501

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena Trupp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	White	Single

6. DATE OF BIRTH

July (Month) 26 (Day) 1914 (Year)

7. AGE ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..2.. hrs. or ..20.. mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry Trupp

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Mary Gettman

13. BIRTHPLACE OF MOTHER (State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Trupp

(Address) Sugar or City Idaho

15. Filed Sept 8 1914 W. Edwards, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1914, to July 26 1914, that I last saw her alive on July 26 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature delivery

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Morefield M. D.

19.... (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford

DATE OF BURIAL: July 27 1914

20. UNDERTAKER: None

ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. 1121, Idaho St.)
File No. 5619
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah A Rowley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Nov (Month) 29 (Day) 1834 (Year)

7. AGE: 79 yrs. 8 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Ennis

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Sally Loomis

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eugene A Rowley
(Address) 1121 Idaho st

15. Filed Sept 10 - 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 1 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1914, to Aug 1st 1914 that I last saw h.es. alive on Aug 1st 1914 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Senile Debility

..... (Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin W Braddock M. D.

Aug 2 1914 (Address) 724 9th Ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Aug 3 1914

20. UNDERTAKER: E J Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewiston
City of Weippe
(No. Gooch Hospital St.)

Registration District No. 96
Primary Registration District No. 1009

File No. [illegible]
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Wm Gaffney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Married

6. DATE OF BIRTH Feb. (Month) 8 (Day) 1873 (Year)

7. AGE 41 yrs. 6 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pierce City

10. NAME OF FATHER Patrick Gaffney

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Bridget Gaffney

13. BIRTHPLACE OF MOTHER (State or Country) Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Dora
(Address) Lewiston,

15.
Filed Sept 10 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1914, to Aug 7 1914
that I last saw h[illegible] alive on Aug 7 1914
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(Duration) yrs. mos. 4 ds.
Contributory (Secondary) Shock
(Duration) yrs. mos. 6 hrs ds.
(Signed) Elmer G. Brodrick M. D.
Aug 8 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Weippe (Country)
Former or usual residence Weippe Ida

19. PLACE OF BURIAL OR REMOVAL: Greer Ida — DATE OF BURIAL: Aug 9 1914

20. UNDERTAKER: [illegible] Carson — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9C
Primary Registration District No. 1009
(No. ....., ... St.)

File No. .....
Registered No. 6
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Michele Minnini

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: Dec (Month) 26 (Day) 1889 (Year)

7. AGE: 24 yrs. 7 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Hand
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Joe Minnini

11. BIRTHPLACE OF FATHER (State or Country): Italy Rosaffrodlia

12. MAIDEN NAME OF MOTHER: Rosa Nicolls

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tony Labellarte
(Address) 8 Myrtle Lewiston

15. Filed Sept 10 1914 C J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Drowned by accident

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C J Perkins M. D.
8/20 1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arrow Junction Ida. DATE OF BURIAL: 8-20- 1914

20. UNDERTAKER: C J Vassar ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston Idaho

Registration District No. Idaho 98
Primary Registration District No. 1009
(No. 408, 3rd St.)

2. FULL NAME James Steele Lytle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Dec 30 1829 (Month) (Day) (Year)

7. AGE: 84 yrs. 7 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired merchant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Andrew Lytle

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Helen Webster Steele

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Geo Tannachill
(Address) Lewiston, Idaho

15.
Filed Sept 10 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 16 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1914, to Aug 16 1914, that I last saw h. im alive on Aug 16 1914 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Arterio-sclerosis

(Duration) 10 yrs. mos. ds.
Contributory (Secondary) Valvular heart disease following rheumatism.
(Duration) yrs. mos. ds.

(Signed) David H. Ransom M. D.
Aug 17 1914 (Address) Clarkston, Wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: Aug 18 1914

20. UNDERTAKER: C. J. Vassar
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. 417, 4th St.)

Registration District No. 96
Primary Registration District No. 1009

File No. 1324
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Catherine Lovelace

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 4 (Day) 1850 (Year)

7. AGE: 63 yrs. 8 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: L. Witmer

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Mrs. Bowman

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. E. Lee
(Address) 714 - 8 Ave

15. Filed Sept 10 - 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 23 1914.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1914, to Aug. 23 1914
that I last saw her alive on Aug. 23 1914
and that death occurred on the date stated above, at 8.30p M.

The CAUSE OF DEATH* was as follows:
Aortic Stenosis

(Duration) 3 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Elmer G. Broadbent M. D.
Aug 29 1914 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 8/30 1914

20. UNDERTAKER: L. Wasson — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 2109
Registered No. 9

1. PLACE OF DEATH.
County of Nez Perce
City of Orchard Tract (No. Orchard Tracts St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sigrid Bozeth

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Feb. (Month) 8 (Day) 1867 (Year)
7. AGE: 47 yrs. 6 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Norway
10. NAME OF FATHER: Ole Olson
11. BIRTHPLACE OF FATHER (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Mollie Thorstenson
13. BIRTHPLACE OF MOTHER (State or Country): Norway
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. A. Bozeth
(Address)
15. Filed Sept. 10 - 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 25 1914, to Aug. 30 1914, that I last saw h.. alive on Aug. 29 1914 and that death occurred on the date stated above, at 3.30 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal Peritonitis

(Duration) Two yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John N Alley M. D.

Aug 31 1914 (Address) Lapwai, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2

Registered No. 37

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Gray

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1861 (Year)

7. AGE: 53 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Gray

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H C Monroe
(Address) Coeur d'Alene Ida

15. Filed July 15 1914 M. L. Leland. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 21 1914, to June 24 1914
that I last saw h[im] alive on June 24 1914
and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hays M. D.
7/14 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: July 15 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 21
County of Blaine Primary Registration District No. 2025
City of Carey (No. ....., ... St.)
File No. 862
Registered No. 15
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME John Kambic
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH: dont know ..... 1 ..... (Month) (Day) (Year)
7. AGE: About 54 years ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: rancher
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Austria
10. NAME OF FATHER: John Kambic
11. BIRTHPLACE OF FATHER (State or Country): Austria
12. MAIDEN NAME OF MOTHER: dont know
13. BIRTHPLACE OF MOTHER (State or Country): dont know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mat Kambic
(Address) Illinois
15. Filed Aug 25 1914 Robert L. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: About Aug (Month) 18 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Did not attend deceased 191.....
that I last saw him alive on ..... 191....., and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Deceased was found dead. Valvular heart affection was probably the cause of death.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John J. Pack M. D.
Aug 21 1914 (Address) Hailey Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida — DATE OF BURIAL: 8/21/1914
20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey Ida

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 14

1. PLACE OF DEATH.

Registration District No. 21

Primary Registration District No. 2024

County of Blaine

City of Hailey (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claudius Duncan Campbell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~ Married

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1/4 (Year)

7. AGE: 57 yrs. 5 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stone Mason
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Md

10. NAME OF FATHER: Isaac Campbell

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Ann Long

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alberta Campbell

(Address) Hailey Idaho

15. Filed Sept 1 1914 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1914, to Aug 26 1914 that I last saw h[illegible] alive on Aug 26 1914, and that death occurred on the date stated above, at 8:30 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) Cerebral Hemorrhage

..... (Duration) 1 yrs. 3 mos. ..... ds.

(Signed) J. J. Plummer M. D.

Sept 1 1914 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida

DATE OF BURIAL: Aug 28 1914

20. UNDERTAKER: R. D. Harris

ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

YMB-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No.
Registered No. 17

1. PLACE OF DEATH.
County of Blaine
City of Bellevue, (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Joseph Toothill

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: Wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Md

6. DATE OF BIRTH: Dec. 25. (Month) (Day) 1878 (Year)

7. AGE: 35 yrs. 7 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia City Nev.

10. NAME OF FATHER: James Toothill

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Toothill
(Address) Bellevue Ida

15. Filed Aug [illegible] 191[illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 20 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 191[illegible] to Aug 20 191[illegible]
that I last saw him alive on Aug 20 191[illegible]
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Internal injuries. Caused by being crushed in a mine

(Duration) yrs. mos. 1 ds.

Contributory (Secondary): none
(Duration) yrs. mos. ds.

(Signed) O. J. Albus M. D.
Aug 20 19 14 (Address) Bellevue Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue Idaho
DATE OF BURIAL: Aug 23 191[illegible]

20. UNDERTAKER: W W Harris
ADDRESS: Hailey Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2024

File No. [illegible]

City of Hailey

(No. ....., ... St.)

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clifford Martin Carpenter

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	Wht	

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

About 27 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) -

10. NAME OF FATHER -

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Letters found on body

(Address) .....

15.

Filed Aug 25 1914

W. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 30 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suicide Strychnine Poison

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Wright M. D.

19.... (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hailey Cem.	Aug 31 1914

20. UNDERTAKER	ADDRESS
W. L. Harris	Hailey Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 821
Registered No. 43

1. PLACE OF DEATH.
County of Kootenai
City of C. W. A.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Hendrie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 47 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Broker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: James Hendrie

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Agnes Ferguson

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Katherine A Hendrie
(Address) .....

15. Filed Aug 8 1914 W. A. Rolan Local Registrar

SYMS - YORK CO., PYRS. & BOAS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 7 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1914, to Aug 7 1914, that I last saw him alive on Aug 7 1914, and that death occured on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:
Multiple Sclerosis

(Duration) 2 Yrs. 6 mos. 7 ds.
Contributory (Secondary) Pernicious Anaemia
(Duration 2 yrs. 1 mos. 7 ds.

(Signed) W. H. Haldeman M. D.
8/7 1914 (Address) Coeur D'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Lawn — DATE OF BURIAL: Aug 9 1914

20. UNDERTAKER: S J Lewis — ADDRESS: C W A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur d'Alene (No. ....., ... St.)
File No. 2
Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachelle Cook

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 16 1838
(Month) (Day) (Year)

7. AGE: 75 yrs. 10 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Donald Cook

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary McDonald

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W J Cook
(Address):

15. Filed Sept 2 1914 W. M. Sheard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 31 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1914, to Aug 27 1914
that I last saw h[er] alive on Aug 27 1914
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Probable Cancer of Stomach

(Duration) Not known yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. D. Mayer M. D.
Aug 31 1914 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem
DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: Cassidy & Nelson
ADDRESS: C D A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 2[illegible]
Registered No. 41

1. PLACE OF DEATH.
County of Kootenai
City of C d A

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H Hansen

If death occurred in a hospital, institution or camp, give the NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 3 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: -

11. BIRTHPLACE OF FATHER (State or Country): -

12. MAIDEN NAME OF MOTHER: -

13. BIRTHPLACE OF MOTHER (State or Country): -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. E. Heidal
(Address) Coeur d'Alene

15. Filed Aug 4 1914 M. S. Ward Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914, to Aug 3 1914, that I last saw him alive on Aug 3 1914, and that death occured on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:
Cancer of the stomach

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cancer

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunby M. D.
Aug 1914 (Address) Coeur d'Alene Idd

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: Aug 7 1914

20. UNDERTAKER: S J Lewis — ADDRESS: C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 8052
Registered No. 44

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D Alene (No. Infant Daughter St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kaylan Peyton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1914 (Year)

7. AGE ....Yrs. ....Mos. 1 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coeur D Alene

10. NAME OF FATHER: Kaylan Peyton

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Ruth Ann

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Victor A. Peyton
(Address):

15. Filed Aug 18 1914 M. McDonald Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 17 1914, to Aug. 18 1914, that I last saw h. Em alive on Aug. 18 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows: Premature birth.

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John D Wood M. D.
Aug 18 1914 (Address) Coeur D'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cedarwood Park — DATE OF BURIAL: Aug 19 1914

20. UNDERTAKER: S J Olsen — ADDRESS: C D A

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8617

Registered No. 45

1. PLACE OF DEATH. Registration District No. 29

County of Kootenai Primary Registration District No. 10 50

City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Maggie Tompkins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH March (Month) 1 (Day) 1871 (Year)

7. AGE 43 yrs. 5 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER John Yong

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Margaret Fairwood

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) W. D. M. P. Mrs Coeur D'Alene

15. Filed Aug 20 1914 W. H. Holland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 16 1914, to Aug 17 1914, that I last saw her alive on Aug 17 1914 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

..... (Duration) Months yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Hayes M. D.
Aug 19 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Forest Cem. DATE OF BURIAL Aug. 1914

20. UNDERTAKER Cassidy & Nelson ADDRESS Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
(No. ..... St.)

File No. 9627
Registered No. 35

1. PLACE OF DEATH.

County of Kootenai
City of C D A

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1839 (Year)

7. AGE: 75 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Worker
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Linstrom

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alfred Larson
(Address) Wolf wood point

15. Filed Jun 24 1914 M. McMaid Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1914, to Jn. 24 1914, that I last saw h[illegible] alive on Jan. 24 1914, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Myers M. D.
6/24 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wolf wood point — DATE OF BURIAL: June 25 1914

20. UNDERTAKER: J J Lee. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 2
Registered No. 34

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Effa Mosell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	White	married

6. DATE OF BIRTH: April (Month) 14 (Day) 1865 (Year)

7. AGE: 44 yrs. 10 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Portland Ontario

10. NAME OF FATHER: Stephen Symington

11. BIRTHPLACE OF FATHER (State or Country): Portland Ontario

12. MAIDEN NAME OF MOTHER: Charlotte Brazier

13. BIRTHPLACE OF MOTHER (State or Country): Portland Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Husband.
(Address)

15. Filed June 11 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1914, to June 6 1914, that I last saw her alive on May 5 1914 and that death occurred on the date stated above, at 1.30 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of uterus

(Duration) yrs. 4 mos. ds.

Contributory (Secondary): None

(Duration) yrs. mos. ds.

(Signed) John Ward M. D.
June 11 1914 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls, Idaho | DATE OF BURIAL: June 13 14

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur D'Alene (No. ..... St.)
File No. 2
Registered No. 33

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME W. P. Moore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Apr (Month) 17 (Day) 1853 (Year)

7. AGE: 61 yrs. 1 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Joseph Moore

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. P. Moore
(Address) Coeur d'Alene

15. Filed Jun 17 1914 Max L. Borland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mon. June 16 1914, to 6 P.M. June 16 1914
that I last saw h[e] alive on June 16 1914
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Diabetic Coma
..... (Duration) ? yrs. ..... mos. 6 hours
Contributory Diabetis
(Secondary)
..... (Duration) ? yrs. ..... mos. ..... ds.
(Signed) John Hunt Physician M. D.
6/17/14 19 ..... (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: June 18 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur d'Alene (No. ....., ... St.)
File No. 8640
Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anton Thorstenson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 4 (Month) — 19 (Day) 1871 (Year)

7. AGE: 43 yrs. 2 mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Karran

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Holmes
(Address) .....

15. Filed June 18 1914 M. McPherland, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1914., to June 18 1914 that I last saw him alive on June 6th 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Busby M. D.

June 18 1914 (Address) Coeur D'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest.
DATE OF BURIAL: June 20 1914.

20. UNDERTAKER: C. A. Nelson.
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8631
Registered No. 31

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George M. Kreiss

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 11 (Day) 1872 (Year)

7. AGE: 42 yrs. 1 mos. 30 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. E. Kreis

11. BIRTHPLACE OF FATHER (State or Country): Newyork

12. MAIDEN NAME OF MOTHER: Marg Spar

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Kreiss
(Address) Coeur D'Alene Ida

15. Filed Jan. 11 1914 M A Dreard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 10th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1912, to June 1914 that I last saw him alive on April 15 1914 and that death occurred on the date stated above, at 3P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the lungs

..... (Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Busby M. D.
June 10 1914 (Address) Coeur D'alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: June 12 1914

20. UNDERTAKER: Passeby & Nelson ADDRESS: Coeur D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [illegible]
Registered No. 30

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur D'Alene (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophie Russell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apr. (Month) 8 (Day) 1871 (Year)

7. AGE: 43 yrs. 2 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Nelson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Russell
(Address) .....

15. Filed June 13 1914 M. S. Hand Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9th 1914, to June 11th 1914
that I last saw her alive on June 11th 1914
and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:
Left Lobar pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Ch. Interstitial Nephritis.
(Duration) 5 yrs. ..... mos. ..... ds.
(Signed) John Hunt Shepherd M. D.
..... 19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: June 14 1914

20. UNDERTAKER: Cassady & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. ....., ... St.)

Registration District No. 29
Primary Registration District No. 1052

File No. 8613
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 12 (Month) 14 (Day) 1883 (Year)

7. AGE: 20 yrs. 6 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work, Laborer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: John Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Sarah Gerda

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ole Johnson
(Address) .....

15. Filed June 24 1914 C Mace H Dorland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 23 (Day) 28 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6th 1914, to June 23 1914, that I last saw him alive on June 23 1914 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage,

..... (Duration) ..... yrs. 4 mos. — ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Busby M. D.
June 23 1914 (Address) Coeur D'alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: June 24 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 8644
Registered No. 46

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Elizabeth Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 9 (Day) 1851 (Year)

7. AGE: 63 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: William H. Murphy

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Mary Baker

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ralph A. Johnson
(Address) Caldwell, Ida.

15. Filed 8-10- 1914
Local Registrar: Jos. S. Meyer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug 8 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17- 1914, to Aug. 8- 1914,
that I last saw her alive on Aug. 8- 1914,
and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Acute nephritis.

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary): Chronic nephritis

(Duration) yrs. mos. ds.
(Signed) Jos. S. Meyer M. D.
8-10/1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge
DATE OF BURIAL: Aug 10 1914

20. UNDERTAKER: W. C. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTGS. & PUBS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

File No. [illegible]

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma J Hildreth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. about Mar 3rd (Month) (Day) 1846 (Year)

7. AGE: about 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Union Grove Township Whiteside Co. Illinois

10. NAME OF FATHER: Thomas Harrison

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ho Not Known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac H Hildreth

(Address) Caldwell Idaho

15. Filed 8-13- 1914

John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 - 1914, to Aug 12 1914, that I last saw her alive on Aug 10 1914, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Dropsy

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J E Troop M. D.

19..... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: to Morrison Ill. DATE OF BURIAL ..... 191...

20. UNDERTAKER: L. C. Morrison ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 7005

(No. ....., ... St.)

2. FULL NAME Joshio Uyematsu

File No. 8646

Registered No. 510

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. May (Month) 13 (Day) 1913 (Year) (1913)

7. AGE: 1 Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Caldwell Idaho

10. NAME OF FATHER: Ushitaro Uyematsu

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Tome Uyematsu

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ushitaro Uyematsu

(Address) Caldwell Idaho

15. Filed 8-14-1914

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..... 191 ..... to ..... 191 ....., ~~that I last saw h~~ alive on ..... 191 ....., and ~~that~~ death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Fracture of skull
Kicked by horse

(Duration) ..... Yrs. ..... mos. ..... ds.

~~Contributory~~ (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. R. Coburn M. D.

8-14-1914 (Address) Nampa Ida Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Aug 14 1914

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOOK. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8647

Registered No. 57

1. PLACE OF DEATH.

County of Canyon

City of Near Middleton

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie E. Edgington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Aug 5 1883 (Month) (Day) (Year)

7. AGE: 31 Yrs. — Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisc

10. NAME OF FATHER A C Vandeventer

11. BIRTHPLACE OF FATHER (State or Country) N. Y

12. MAIDEN NAME OF MOTHER Harriet Bullings

13. BIRTHPLACE OF MOTHER (State or Country) Wise

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. S. J. Doolittle
(Address) Boise Idaho

15. Filed 8-14-1914 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1914, to Aug 13 1914, that I last saw h-s alive on Aug 13 1914 and that death occured on the date stated above, at 12 10 M.

The CAUSE OF DEATH* was as follows: Tuberculosis of Lungs

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J B Cox M. D.

8/14 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton Ada — DATE OF BURIAL: Aug 15 1914

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Ada

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell, Idaho (No. ....., ... St.)

File No. 8013

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Hartman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Single

6. DATE OF BIRTH. June (Month) 26 (Day) 1869 (Year)

7. AGE 45 Yrs. ..... Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs S. L. Spurgeon

(Address) Canyon Hospital

15.

Filed Aug 18 1914 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1914, to Aug 16 1914, that I last saw him alive on Aug 16 1914 and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

General Peritonitis - result of ruptured Appendix

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Hall M. D.

Aug 17 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salt Lake City — DATE OF BURIAL ..... 191.....

20. UNDERTAKER F K Robinson — ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

File No. 610

Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Moon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sing.

6. DATE OF BIRTH. 8 (Month) 16 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Caldwell Idaho

10. NAME OF FATHER: Claude Moon

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Marion Morrison

13. BIRTHPLACE OF MOTHER (State or Country): S. Dak

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Caldwell Idaho

15. Filed 8-18-1914 Jobd Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/16 1914, to 8/18 1914, that I last saw him alive on 8/18/14 1914, and that death occured on the date stated above, at 10a.m.

The CAUSE OF DEATH* was as follows:

General inanition

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary) Undersized and very weak from birth

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lee M. D.

8/18/1914. (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Aug 18 1914

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8650

Registered No. 54

Registration District No. 3

Primary Registration District No. 2005

1. PLACE OF DEATH.

County of Canyon

City of Caldwell (Ward No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Diana Berry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 3 (Day) 1832 (Year)

7. AGE: 81 Yrs. 7 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Moyer

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Diana Kisling

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. F. Berry
(Address) Caldwell Idaho

15. Filed Aug. 25 1914 — Jas. S. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/18 1914, to 8/24 1914, that I last saw her alive on 8/18 1914 and that death occured on the date stated above, at 8.30 A. M.

The CAUSE OF DEATH* was as follows:
General debility caused by hypostatic pneumonia

(Duration) Yrs. ..... mos. 6 ds.

Contributory (Secondary): General debility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lord M. D.

8/24 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Aug 25 1914

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. [illegible]
Registered No. 55

1. PLACE OF DEATH.
County of Canyon
City of Idaho Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Lorden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
February (Month) 1 (Day) 1839 (Year)

7. AGE 75 yrs. ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Nancy Payne

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. G. Lorden
(Address) Caldwell, Idaho,

15.
Filed 8-31- 1914
John S. Meyers
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1914, to Aug 29 1914, that I last saw her alive on Aug 29 1914, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Uraemia

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Miller M. D.
Aug 31 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: W. E. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell Rural R

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

File No. [illegible]

Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Solomon Brodle.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May (Month) 14 (Day) 1830 (Year)

7. AGE: 84 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Samuel Bodle.

11. BIRTHPLACE OF FATHER (State or Counfry) Hort Knox

12. MAIDEN NAME OF MOTHER Hort Knox

13. BIRTHPLACE OF MOTHER (State or Country) Hort Knox

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Bodle
(Address) Nampa Idaho.

15.
Filed Sept 2 1914
John L. Meyers
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sep (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1914, to Sept 1 1914, that I last saw h[illegible] alive on Sept 1 1914, and that death occured on the date stated above, at 1 9 M.

The CAUSE OF DEATH* was as follows:
Heart failure due to shock, Gas on stomach and an old rheumatic heart

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Miller M. D.
Sept 1 1914 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Sept 2 1914

20. UNDERTAKER: W. C Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8653

Registered No. 57

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Caldwell Rural (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles L. Tatum.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 15 (Day) 1857 (Year)

7. AGE: 57 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: James H. Tatum

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. F. Bergler
(Address) Caldwell Rout. # 2

15. Filed Sept. 5 1914 — John S. Jones, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24" 1914, to Sept 3" 1914, that I last saw h. in alive on Sept 3" 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Alcoholism.

Hrt. (Duration) one Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Munn — M. D.
9-5-1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 9/11/5 1914

20. UNDERTAKER: Jones Furniture Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BOOS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 7
County of Canyon Primary Registration District No. 1006
City of Nampa (No. 901-15 ave So. St.)
File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Davis Badgley.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: March (Month) 30th (Day) 1907 (Year)

7. AGE: 7 yrs. 5 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nampa Canyon Co. Idaho

10. NAME OF FATHER Albert H. Badgley

11. BIRTHPLACE OF FATHER (State or Country) Vernon Co. Mo

12. MAIDEN NAME OF MOTHER Lucy Davis.

13. BIRTHPLACE OF MOTHER (State or Country) Moniteau Co. Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Davis.
(Address) Nampa Idaho.

15.
Filed Sept 8 1914 D W S Colonge Local Registrar
Deputy.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1914, to Sept 6 1914 that I last saw him alive on Sept 6 1914, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Meningitis - Following Typhoid Fever relapse

(Duration) yrs. 1 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. T. Murray M. D.
Sept 8 1914 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Robbersown - Nampa
DATE OF BURIAL: Sept 8 1914

20. UNDERTAKER: F. W. Robinson
ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Anna Hatfield Deputy.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 7
County of Boise Primary Registration District No.
City of Lake Fork (No. , St.)
File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H. B. Coons

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 60 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Train Conductor
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mattie Harris
(Address) Nampa Ida

15. Filed Sept 5- 1914 W S D Calouge Local Registrar
Anna Hatfield Deputy Reg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..... 191..., to ..... 191...
that I last saw ~~h~~ ..... alive on ..... 191...,
and ~~that~~ death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Run over by Train Accidental
Coroners Inquest
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F K Wallace Coroner ~~M. D.~~
Sept 3rd 1914 (Address) Nuseberry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. ~~PLACE OF BURIAL~~ OR REMOVAL: Pocatello Ida
DATE OF BURIAL: — 191...

20. UNDERTAKER: F. K. Robinson
ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2007

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 46 8656

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon Lee

City of .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances Loxine Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Aug (Month) 19 (Day) 1836 (Year)

7. AGE: 78 Yrs. 8 Mos. 12 ds. IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Andrew Estelle

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: A. Rogers

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. F. Hall
(Address) Parma Idaho

15. Filed Sept 9 1914

R. W. Waldo
Sept 9 — Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 1st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 29 1914, to Sept. 1st 1914, that I last saw h-r alive on Aug. 30 1914, and that death occured on the date stated above, at 12-00 M.

The CAUSE OF DEATH* was as follows:
Shock - result of fall

.....(Duration) — Yrs. — mos. 3 ds.
Contributory (Secondary): Senile debility

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. W. Waldo M. D.
19..... (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? At home
Former or usual residence Do not know

19. PLACE OF BURIAL OR REMOVAL: Parma, Idaho — DATE OF BURIAL: Sept 1914

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8655

Registered No. .....

1. PLACE OF DEATH.

County of Elmore

City of Glens Ferry

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. 2 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Hurst

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 22nd (Day) 1830 (Year)

7. AGE: 84 Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)... ~~Pembrookshire~~ Wales

9. BIRTHPLACE (State or Country) Pembrookshire Wales

10. NAME OF FATHER John Jones

11. BIRTHPLACE OF FATHER (State or Country) Pembrookshire Wales

12. MAIDEN NAME OF MOTHER Mary Jones

13. BIRTHPLACE OF MOTHER (State or Country) Pembrookshire Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Hurst

(Address) Glens Ferry Idaho

15.

Filed Sept. 1st 1914 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th 1914, to Aug 9th 1914, that I last saw h[er] alive on Aug 9th 1914, and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast

(Duration) 1 Yrs. 8 mos. 11 ds.

Contributory (Secondary) Exhaustion

(Duration ..... yrs. one mos. — ds.

(Signed) W. F. Morrison M. D.

1914 (Address) Glens Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: [illegible] 1914

20. UNDERTAKER: [illegible] ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
(No. ....., ... St.)

File No. .....
Registered No. 47
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kat Mauck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Single

6. DATE OF BIRTH
Aug (Month) 30 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* 15 *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Viola

10. NAME OF FATHER J. F. Logan

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mary Bolter

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Mayfield
(Address) .....

15. Filed Aug 31 1914 J. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. M. Mayfield, M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Viola — DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: Moore — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. [illegible]
Registered No. 49

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mossie M. Lauritson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 3 1870 (Month) (Day) (Year)

7. AGE: 44 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: L. L. Lauritsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Betrisse Bieghelsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. L. Lauritsen
(Address) Moscow

15. Filed Aug 7 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 7 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1914, to Aug 7 1914, that I last saw her alive on Aug 6 1914 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Epilepsy

(Duration) 40 yrs. ..... mos. ..... ds.

(Signed) D. F. Rae M. D.

Aug 7 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 8/9 1914

20. UNDERTAKER: Lee Stolz
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

Primary Registration District No. 1014

File No. 8661

County of Latah

City of Moscow (No. ....., ... St.)

Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph B. Rush

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: June (Month) 7 (Day) 1873 (Year)

7. AGE: 41 yrs. 2 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Joseph Rush

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Elizabeth Rush

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Hisel
(Address) Moscow Ida

15. Filed Aug 29 1914 L F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10 1914, to Aug 28 1914, that I last saw h[illegible] alive on Aug 27 1914, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ..... ds.

Contributory (Secondary) Pulmonary emfysema

(Duration) yrs. ..... mos. 14 ds.

(Signed) Joseph Asbury M. D.

Aug 29 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: aug 30 1914

20. UNDERTAKER: Geo Stolz | ADDRESS: Moscow

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 1011
(No. ..... St.)

File No. 5868
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. N. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Single

6. DATE OF BIRTH: June (Month) 10 (Day) 1 (Year)

7. AGE: 43 yrs. 7 mos. 19 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Stone Cutter

9. BIRTHPLACE (State or Country) ~~Iowa~~ Iowa

10. NAME OF FATHER Samuel G Smith

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Julia N Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George E Smith
(Address) Moscow

15. Filed Aug 29 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 27 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1914, to Aug 29 1914, that I last saw him alive on Aug 28 1914 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 7 yrs. mos. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. mos. ds.

(Signed) D F Rae M. D.
Aug 29 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Aug 30 1914

20. UNDERTAKER: Geo Stelz — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

Primary Registration District No. 1011

File No. 8663

County of .....

City of ..... (No. ....., ... St.)

Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Florence Carr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec 18 (Month) 1891 (Year) (Day) 1

7. AGE: 23 yrs. 8 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Helix Oregon

10. NAME OF FATHER: Harry P. Tracy

11. BIRTHPLACE OF FATHER (State or Country): Salinas, Calif

12. MAIDEN NAME OF MOTHER: Ada Baugh

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lorraine M Tracy
(Address): Moscow Ida

15. Filed Sept 7 1914 J F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Sept 7th 1914; that I last saw her alive on Sept 7 1914 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) ..... yrs. Two mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W R Adair M. D.

Sept 7 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 9/8 1914

20. UNDERTAKER: Gay Bell — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8664
Registered No.

1. PLACE OF DEATH.
County of Clearwater
City of Lenore R.F.D.
Registration District No. 16
Primary Registration District No. 2075
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Christena FaeRenthal

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widow

6. DATE OF BIRTH: June (Month) 22 (Day) 1855 (Year)

7. AGE: 58 yrs. 9 mos. 28 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pa

10. NAME OF FATHER: Samuel FaeRenthal

11. BIRTHPLACE OF FATHER (State or Country): V

12. MAIDEN NAME OF MOTHER: V

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. A. FaeRenthal
(Address) Lenore R.F.D. Idaho

15. Filed 4-20 1914 J. M. Lytle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: apr (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from apr 11 1914, to apr 20 1914
that I last saw her alive on apr 19 1914
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Septic Infection
from boil or abscess

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Lytle M.D.
4-20 1914 (Address) Pedro Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sunnyside Cemetery
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Stoddard
ADDRESS: Gifford Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M-7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nezperce
City of Peck

Registration District No. 16
Primary Registration District No. 2075
(No. ....., ... St.)

File No. [illegible]
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nora E Liefer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 25 (Day) 1887 (Year)

7. AGE: 26 yrs. 4 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ore

10. NAME OF FATHER: Phillip Johnson

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mary L. Groom

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Philip Johnson
(Address) Peck Ida

15. Filed 3-7 1914 J. M. Ly[illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-10 1914, to Mar 5 1914
that I last saw h[illegible] alive on about date 191....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Ly[illegible] M. D.
3-5 1914 (Address) Peck

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Peck
DATE OF BURIAL: 3-7 1914

20. UNDERTAKER: Nave
ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form-V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8666
Registered No.

1. PLACE OF DEATH.
County of Nez Perces
City of Peck
Registration District No. 19
Primary Registration District No. 2075
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gemima Jackson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Jan. (Month) 8 (Day) 1832 (Year)

7. AGE: 82 yrs. ..... mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Va

10. NAME OF FATHER: Elijah Spencer

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Polly Sturgeon

13. BIRTHPLACE OF MOTHER (State or Country): Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gemima Logan
(Address) Peck Ida

15.
Filed 2-4 1914 J. M. Fyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-24 1913., to Feb. 2 1914
that I last saw h[illegible] alive on above date 191....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Sarcoma of Stomach

..... (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Fyle M. D.
2-3 1914 (Address) Pee-R Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pee R Ida
DATE OF BURIAL: Feb. 6 1914

20. UNDERTAKER: None
ADDRESS: /

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RESERVED FOR BI... UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8667

Registered No.

1. PLACE OF DEATH.
County of Nez Perce
City of Peck

Registration District No. 14
Primary Registration District No. 2075
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melissia Alice Fine

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 28 (Month) 1864 (Day) (Year)

7. AGE: 49 yrs. 6 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jackson Graham

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: M. J. McKinney

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Graham
(Address) Elgin Ore

15. Filed 2-6 1914 J. M. Lyle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1914, to Feb 3 1914
that I last saw her alive on Feb 3 1914
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Sarcoma of mesentery

..... (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Lyle M. D.
2-6 1914 (Address) Peck

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Peck
DATE OF BURIAL: 2-7 1914

20. UNDERTAKER: None
ADDRESS: -

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

AYER-YORK CO., PRINTERS & BINDERS. 50151 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perces
City of Melrose

Registration District No. 16
Primary Registration Distt No. 2075
(No. ....., ..., St.)

File No. 5668
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Mar (Month) 25 (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Geo. E. Kimball

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Emma A. Finley

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo E Kimball
(Address) Melrose Idaho

15.
Filed May 26 1914 J. M. Lyle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: No Physician

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Melrose
DATE OF BURIAL: 5-6 1914

20. UNDERTAKER: Noce
ADDRESS: L

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8669
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2010
Primary Registration District No. 2010
(No. ....., ... St.)

2. FULL NAME Stephen B. Edmunds

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE 36 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Stephen J Edmunds

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Isabella M. Ross

13. BIRTHPLACE OF MOTHER (State or Country) [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A E Ross
(Address) Rupert Ida.

15.
Filed 7-15 1914 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to date 191
that I last saw h[illegible] alive on July 13 1914,
and that death occurred on the date stated above, at 3-15 P M.

The CAUSE OF DEATH* was as follows:
Perforative Typhoid Fever,
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) B. O. Clark M. D.
7-14 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Manchester Iowa
DATE OF BURIAL 191

20. UNDERTAKER C S Bucknum
ADDRESS Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett
(No. 0, St.)

Registration District No. 2010
Primary Registration District No. 1010

File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma J. Banks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widow

6. DATE OF BIRTH: Oct. (Month) 11 (Day) 1860 (Year)

7. AGE: 53 yrs. 9 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Henry Beachler

11. BIRTHPLACE OF FATHER (State or Country): Indian

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): A B Banks
(Address): Banks Idaho

15.
Filed 8-11 1914 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1914, to Aug 7 1914, that I last saw he alive on Aug 7 1914, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 1 yrs. 6 mos. ds.

Contributory (Secondary) Myocarditis and arterio sclerosis

(Duration) yrs. mos. ds.

(Signed) J L Reynolds M. D.
8-11 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: Aug 10 1914

20. UNDERTAKER: C D Bucknum
ADDRESS: Emmett

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett (No. ....., ... St.)
Registration District No. 2010
Primary Registration District No. 1020

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte M. Hall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	married

6. DATE OF BIRTH Nov (Month) 14 (Day) 1871 (Year)

7. AGE 42 yrs. 9 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Geo W. Brinnon

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Nancy Jane Smith

13. BIRTHPLACE OF MOTHER (State or Country) [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Hall
(Address) Emmett Idaho

15.
Filed 8-19-1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug 16 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sprng of 1913, to Aug - 1914, that I last saw her alive on about Justy 20 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency
.....
.....
(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.
8-20-1914 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Emmett Cemetery — DATE OF BURIAL Aug 17 1914

20. UNDERTAKER [illegible] — ADDRESS [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7010
Primary Registration District No.
(No. ..... St.)

File No.
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charles Oakes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec 11 (Month) (Day) 1830 (Year)

7. AGE: 83 yrs. 7 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Asa Oakes

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Hannah Carlton

13. BIRTHPLACE OF MOTHER (State or Country): New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Horace Oakes
(Address): Boise Idaho

15.
Filed 8-20 1914 J. J. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1914, to July 29 1914
that I last saw him alive on June 22 1914
and that death occurred on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:
Heart Disease Jaundiced
(Duration) yrs. 2 mos. 7 ds.
Contributory (Secondary) Old age
(Duration) yrs. mos. ds.

(Signed) Jno Sawyer M. D.
19 (Address) Middleton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: July 30 1914

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 53
County of Blaine Primary Registration District No. 2138 File No. [illegible]
City of Hailey (No. ....., ... St.) Registered No. 120
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Mary A Jones
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Nov. (Month) 2 (Day) 1857 (Year)

7. AGE: 57 yrs. 9 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): MO

10. NAME OF FATHER: Mr. Darby

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss S. A. Stokes
(Address) Hailey Idaho

15. Filed Aug 13 1914 A. O. Higgins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1914, to Aug 12 1914, that I last saw h[illegible] alive on Aug 11 1914, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
..... (Duration) — yrs. — mos. — ds.
Contributory (Secondary) Fatty Degeneration of heart
..... (Duration) 1 yrs. — mos. — ds.
(Signed) C C Higgins M. D.
8.13 1914 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hyde City — DATE OF BURIAL: Aug 14 1914

20. UNDERTAKER: Ira Monnett — ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36
Primary Registration District No.
(No. ..... , ... St.)

File No. 2
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna Loral Tucker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
Oct (Month) 27 (Day) 1913 (Year)

7. AGE
yrs. 9 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Farming

9. BIRTHPLACE (State or Country) Kimberly Ida.

10. NAME OF FATHER L. L. Tucker

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Edna McKenzie

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. L. Tucker
(Address) Kimberly

15.
Filed Aug. 22 1914 Dr. F. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug. (Month) 22nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22nd 1914, to Aug 22nd 1914, that I last saw h[illegible] alive on Aug 22nd 1914, and that death occurred on the date stated above, at 11 35 P.M.

The CAUSE OF DEATH* was as follows:
Cholera infantum

about 3
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Pike M. D.
8/22/1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Aug 23 1914
20. UNDERTAKER	ADDRESS
P. J. Freeman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5144
Registered No. 11

1. PLACE OF DEATH.
County of Custer
City of Custer
(No. ....., ... St.)

Registration District No. 43.
Primary Registration District No. 2120

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth McLeod

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Unknown. (Month) (Day) 1854 (Year)

7. AGE
60 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Leland
(Address) Custer City Idaho

15.
Filed August 16 1914 W. N. Schumpler M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August, (Month) 14, (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1914, to August 14 1914
that I last saw him alive on August 13, 1914
and that death occurred on the date stated above, at 4. P. M.

The CAUSE OF DEATH* was as follows:
Fibroid Phthisis, (Miners Consumption),
..... (Duration) five yrs. — mos. — ds.
Contributory (Secondary) Chronic Nephritis,
..... (Duration) one yrs. 6 mos. — ds.
(Signed) W. N. Schumpler M. D.
Aug. 15, 1914 (Address) Silver City, Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Custer City Cty K of P Cemetary
DATE OF BURIAL: Aug 16 1914

20. UNDERTAKER: John Grete
ADDRESS: Custer City Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2193
File No. 1
Registered No. 21

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth Calvin Moser

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 27 (Day) 1913 (Year)

7. AGE: 1 yrs. 4 mos. 2 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Calvin Moser

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Cora Soderstrom

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Calvin Moser
(Address) Aberdeen Ida

15. Filed Aug 31 1914 Memo Timmons Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 29 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on ..... 191...,
and that death occurred on the date stated above, at 10½ M.

The CAUSE OF DEATH* was as follows:
Accidental drowning.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Memo Timmons M. D.
Aug 31 1914 (Address) Aberdeen Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Interment to Cemetery — DATE OF BURIAL: Sept 1 1914

20. UNDERTAKER: Actg C. Moser — ADDRESS: Aberdeen Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 50

Primary Registration District No. 2129

File No.

Registered No. 18

1. PLACE OF DEATH.

County of Gem

City of Ilo

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Warren Barton Stone Bowles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 29 (Day) 1839 (Year)

7. AGE: 74 Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Adams Co Ill

10. NAME OF FATHER Holman Bowles

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Salina Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W. B. Bowles

(Address) Ilo Idaho

15.

Filed Aug 25 1914

H. C. Parrish
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1914, to Aug 25 1914, that I last saw him alive on Aug 25 1914, and that death occured on the date stated above, at 12-30 P.M.

The CAUSE OF DEATH* was, as follows:

Accident

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos ..... ds.

(Signed) H. C. Parrish M. D.

8-25 1914 (Address) Ilo. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ilo. I.O.O.F. Cemetary

DATE OF BURIAL: 8-30 1914

20. UNDERTAKER: J. J. Wood

ADDRESS: Ilo. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 109

Primary Registration District No. 2187

File No.

County of Custer

City of Mackay (No. ....., ... St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vera Emily Bartlett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: March 30 1897 (Month) (Day) (Year)

7. AGE: 17 yrs. 4 mos. 24 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jerome Bartlett

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Mabel Bascom

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jerome Bartlett

(Address) Mackay, Idaho

15. Filed 9/1 191[illegible] F. O. Richards Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 25th, 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1 191[illegible], to July 25 191[illegible], that I last saw h[illegible]er alive on July 25 191[illegible], and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 7 yrs. mos. ds.

Contributory (Secondary) Acute Cardiac Dilatation

(Duration) yrs. 5 mos. ds.

(Signed) F. O. Richards M. D.

July 26 1914 (Address) Mackay, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mackay, Idaho

DATE OF BURIAL: July 27 1914

20. UNDERTAKER: Garletz

ADDRESS: Mackay,

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Custer
City of Mackay

Registration District No. 109
Primary Registration District No. 2187
(No. ....., ... St.)

File No. 2887
Registered No. 147

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marco Jacenelli

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	Italian	married

6. DATE OF BIRTH — — 1879
(Month) (Day) (Year)

7. AGE 35 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Copper Miner
(b) General nature of industry business or establishment in which employed (or employer): Empire Copper Co

9. BIRTHPLACE (State or Country): Italy - Lombardy

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Dont know Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ambrose Caro
(Address) Mackay Ida

15. Filed 9/10 191 4 F. S. Richards
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1914, to Aug 18 1914
that I last saw him alive on Aug 18 1914
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Crushed by falling rock while working in mine.
Instantaneous
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) R. E. Mason M. D.
Aug 21 1914 (Address) Mackay Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mackay Idaho
DATE OF BURIAL: Aug 21 1914

20. UNDERTAKER: Chas F Baker
ADDRESS: Mackay

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8656
Registered No. 23

1. PLACE OF DEATH.
County of Kootenai
City of Lane
Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Lowey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: June (Month) 10 (Day) 1912 (Year)
7. AGE: 3 yrs. 1 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idho Kootenai
10. NAME OF FATHER: Frank Lowey
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Celia Cody
13. BIRTHPLACE OF MOTHER (State or Country): Irish
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sidney Cody
(Address) Coeur d'Alene Idaho
15. Filed Sept 7-1914 (~~Sept 8~~) 1914
R. S. Jensen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 27 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1914, to Aug 27 1914
that I last saw h[illegible] alive on Aug 26 1914
and that death occurred on the date stated above, at 10 A M.
The CAUSE OF DEATH* was as follows:
Acute gastro-enteritis
..... (Duration) ..... yrs. ..... mos. 12 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Mowery M. D.
Aug 27 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lane Id
DATE OF BURIAL: 8/29 1914
20. UNDERTAKER: Ed Mc Lean
ADDRESS: Harrison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Harrison (No. ....., ... St.)

Registration District No. 126
Primary Registration District No. 2204

File No. 8687
Registered No. 1224

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Comptan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: ~~July~~ ~~29~~ ~~30~~ 1914
(Month) (Day) (Year)

7. AGE: 30 yrs. × mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ino.

10. NAME OF FATHER: Jer Compton

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Alice Colem

13. BIRTHPLACE OF MOTHER (State or Country): Ino

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ida Kazer
(Address) Harrison Ida

15.
Filed Sept 7 1914 R. L. Jensen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. 30 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1914, to Aug 30 1914
that I last saw h... alive on Aug 30 1914
and that death occurred on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever.

..... (Duration) ..... yrs. ..... mos. 21 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tenney M. D.
Aug 30 1914 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida — DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: Coeur d'Alene — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. 22

1. PLACE OF DEATH.

County of Kootenai

City of Harrison (No. .... St.)

Registration District No. 126

Primary Registration District No. 2204

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Elmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1846 (Year)

7. AGE: 67 Yrs. 10 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER William Hoosier

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Miss Easter

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nellie E. Smith
(Address) Harrison Ida

15. Filed Aug 22 1914 — W. S. Jensen, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1913, to Aug 20 1914, that I last saw h alive on Aug 20 1914, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) E. L. Ryker M. D.

19..... (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harrison	Aug 21 1914
20. UNDERTAKER E. W. Wheeler	ADDRESS Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Winona
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ..., ... St.)

14
File No. [illegible]
Registered No. ...
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Chester Nils Asker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 13 (Day) 1913 (Year)

7. AGE: 1 yrs. ... mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Oscar Asker

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Belle Josephine Rekdahl

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Oscar Asker
(Address): Winona, Idaho

15.
Filed Aug 13 1914 — W. H. Blake, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1914, to Aug. 13, 1914
that I last saw him alive on Aug. 13, 1914,
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Acute Gastro-enteritis

(Duration) ... yrs. ... mos. 1 ds.
Contributory (Secondary): Marasmus
(Duration) 1 yrs. ... mos. ... ds.

(Signed) J. W. Burner M. D.
Aug. 13, 1914 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida — DATE OF BURIAL: Aug. 14 1914
20. UNDERTAKER: Harry M West — ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183

File No. 17 8690
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Pelton L Dutcher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): Widower

6. DATE OF BIRTH: August 14 (Month) (Day) 1857 (Year)

7. AGE: 57 yrs. ..... mos. one ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ulster Co county Newyork

10. NAME OF FATHER: Orlando Dutcher

11. BIRTHPLACE OF FATHER (State or Country): Newyork

12. MAIDEN NAME OF MOTHER: Mahaleth Burnham

13. BIRTHPLACE OF MOTHER (State or Country): Newyork

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orean A Dutcher
(Address) Cottonwood Idaho

15.
Filed Aug 15 1914 H Tobleman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1914, to Aug 13 1914 that I last saw h im alive on Aug 13 1914, and that death occurred on the date stated above, at 4.30 P M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis

..... (Duration) 3 yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Shumack M.
Aug 15 1914 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Idaho | DATE OF BURIAL: Aug 16 1914
20. UNDERTAKER: Hagey & West | ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS-YORK CO., PRINTERS & RULERS. BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183

File No. 18 6691
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Shallenger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: October (Month) 18 (Day) 1854 (Year)

7. AGE: 59 yrs. 9 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Shallenger

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: not Known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Shallenger
(Address) Cottonwood Ida

15.
Filed Aug 22 1914 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12th, 1914, to May 25th, 1914, that I last saw him alive on June 28th, 1914, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Turner, M. D.
8-22-1914 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida
DATE OF BURIAL: Aug 23 1914

20. UNDERTAKER: Harry M West
ADDRESS: Cottonwood Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 19 8692
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Kenterville
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed infant of Nels Juhl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Single (Write the word.)

6. DATE OF BIRTH.
Aug (Month) 23 (Day) 1914 (Year)

7. AGE
.....Yrs.....Mos.....ds.
IF LESS than 1 day how many 15 hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Nels Juhl

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Florence Williams

13. BIRTHPLACE OF MOTHER
(State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nels Juhl
(Address) Kenterville Ida

15.
Filed Aug 24 1914 H W Blake Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from 191 , to 191~~ investigated the death of death of deceased, ~~that I last saw h alive on~~ Aug 23 1914, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows: Corpus infans
Premature birth at 8 month

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) H W Blake M. D.

Aug 24 1914 (Address) Coroner Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Idaho	Aug 25 1914
20. UNDERTAKER	**ADDRESS**
Ward Williams	Kenterville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2131

File No. 8604

County of Boise

City of Arrowrock (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jose Valla

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. ? (Month) ..... 1 (Day) ..... (Year)

7. AGE ? Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... (concrete man)

9. BIRTHPLACE (State or Country) Mexico

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) Mexico

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James P Kerby

(Address) Arrowrock, Ida.

15. Filed July 31 1914 James P Kerby M.D. Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1914, to July 31 1914, that I last saw h[illegible] alive on July 31 1914, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Traumatic Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 3 hrs. ..... ds.

Contributory (Secondary) fracture, base of skull

(Duration 3 hours yrs. ..... mos ..... ds.

(Signed) James P Kerby M. D.

July 31 1914 (Address) Arrowrock, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

3 hrs.

Where was disease contracted if not at place of death? —

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise, Ida — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Shrecher & Siddenfadden — ADDRESS

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8695
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Kamiah, (Precinct)

Registration District No. 49
Primary Registration District No. 1728
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James Owen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: 4 (Month) 24 (Day) 1914 (Year)

7. AGE: 0 yrs. 3 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kamiah

10. NAME OF FATHER: Otto Owen

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Jessie McHarge

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto Owen
(Address) Kamiah

15. Filed 8/5 1914 W. F. McMahan, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from not at all 191..., to ..... 191...
that I last saw h... alive on ..... 191...
and that death occurred on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:
Dr. C. H. Bryan, Called, arrived 1 hr. after death, (refuses to make out this certificate). Father states Cholera Infantum
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory —
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.
8/4 1914 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: K. Of P. Cemetery — DATE OF BURIAL: 8/4 1914

20. UNDERTAKER: C. F. Johnson — ADDRESS: Kamiah

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Kamiah

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

File No. 8696
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonard W. Moore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 11 (Month) 9 (Day) (Twins) 1895 (Year)

7. AGE: 18 yrs. 9 mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lived at home
(b) General nature of industry business or establishment in which employed (or employer): father

9. BIRTHPLACE (State or Country): Spokane

10. NAME OF FATHER: Wm S. Moore

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lucy J. Woods

13. BIRTHPLACE OF MOTHER (State or Country): Illis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William S. Moore
(Address) Kamiah, Ida.

15.
Filed 8/4 1914
W. H. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from not at all 191..., to ..... 191.....
that I last saw h— alive on — 191.....
and that death occurred on the date stated above, at 1100 P. M.

The CAUSE OF DEATH* was as follows:
Drowned in the Clearwater River

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. McMahan M. D.
8/4 1914 (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash
DATE OF BURIAL: Aug 4 1914

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 220
(No. ..... St.)

File No. 8697
Registered No. 25

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Graf

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wallace

10. NAME OF FATHER Chas. Graf.

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Annie Angli

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. Graf.
(Address) Wallace Ida.

15. Filed Aug 1 1914 W. C. Mowry Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Premature Birth
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) W. C. Mowry M. D.
(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace Ida — DATE OF BURIAL ..... 191...

20. UNDERTAKER Ward Undertaking — ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8698
Registered No. 14

1. PLACE OF DEATH.
County of Shoshone
City of Burke Idy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 2202
(No. Glen's Reduced House St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs H Draper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE. 33 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER not Known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jos H Heromann
(Address) Wallace Ida

15. Filed 7/12 1914 H. S. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1914, to July 10 1914, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Chas. R. Mowry M. D.
July 11 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho — DATE OF BURIAL July 14 1914

20. UNDERTAKER Breen & Worstell — ADDRESS Wallace Ida

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BORS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Id[illegible]
BOARD OF H[illegible]
Bureau of Vital [illegible]

1. PLACE OF DEATH.
County of Idaho.
City of Woodland

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

File No. 8699
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen Emery

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: ? (Month) ..... 1 (Day) ? (Year)

7. AGE: About 53 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gas Blacksmith
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Frank Emery

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Emily Huntington

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L O Moon
(Address) Harrisburg

15. Filed 7/21 1914 Lot-Jr McMahan. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 13th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10th 1914., to Present 191.. that I last saw him alive on July 12 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C H Duncan M. D.
7/14 1914 (Address) Kelmar Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodland Cem. DATE OF BURIAL: 7/14 1914

20. UNDERTAKER: C. B. Scott ADDRESS: Woodland.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-1?

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 87001

Registered No. 189

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jas. Daniels

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Sarah J. Crandy

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. A. Brown

(Address) .....

15. Filed June 10 1914 — O. B. Neely, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... June (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1914 to June 9 1914, that I last saw h.. alive on June 9 1914, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows: Abscess. Brain.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) N. Banks Williams M. D.

19 14 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bancroft Idaho — DATE OF BURIAL 1914

20. UNDERTAKER: Nelson Undertaking Co — ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8701
Registered No. 190

Registration District No. 2
Primary Registration District No. 2161

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 6 E. N. 4th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie C. Gates

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Italian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): Widow

6. DATE OF BIRTH. Aug (Month) 20 (Day) 1831 (Year)

7. AGE: 82 Yrs. 9 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Ida Gates
(Address) .....

15. Filed June 21, 1914 — O. J. Green, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to June 17 1914, that I last saw her alive on June 16 1914, and that death occured on the date stated above, at 5:45 a M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) Several Yrs. — mos. — ds.

Contributory (Secondary) Ascites Oedema nephritis

(Duration) — yrs. 3 mos. — ds.

(Signed) W. J. Howard M. D.

10/19 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Wallace & Wann — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8110
Registered No. 31

1. PLACE OF DEATH. Registration District No. 7 0
County of Washington Primary Registration District No. 1010
City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs E. Viola Hamm

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug — — 1 (Month) (Day) (Year)

7. AGE: 41 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): State of Iowa

10. NAME OF FATHER: Leslie Andrews

11. BIRTHPLACE OF FATHER (State or Country): State of Penn.

12. MAIDEN NAME OF MOTHER: Margaret McConnell

13. BIRTHPLACE OF MOTHER (State or Country): State Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. F. Hamm
(Address) Weiser, Ida

15. Filed July 9 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July — 8 — 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1914, to July 8 1914
that I last saw her alive on July 8 1914
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James A. Young M. D.
7/9/ 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma Ida — DATE OF BURIAL: July 9 1914

20. UNDERTAKER: R. W. Bowen — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8703
Registered No. 32

1. PLACE OF DEATH. Registration District No. 96
County of Washington Primary Registration District No. 2112
City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm L. Williams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: April (Month) – 23 (Day) – 1839 (Year)
7. AGE: 75 yrs. 2 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Howard Co., Mo.
10. NAME OF FATHER: Fielding Williams
11. BIRTHPLACE OF FATHER (State or Country): Jefferson Co., Ky
12. MAIDEN NAME OF MOTHER: Mary A. Collett
13. BIRTHPLACE OF MOTHER (State or Country): Madison Co. Ky
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel R. Williams
(Address) Weiser Ida
15. Filed July 10th 1914 W. R. Brumbach Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) – 6 (Day) – 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 22nd, 1914, to July 5th 1914
that I last saw h[illegible] alive on July 5th 1914
and that death occurred on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. R. Brumbach M. D.
July 10 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Smithville Mo. DATE OF BURIAL: July 15 1914
20. UNDERTAKER: J. W. Bowen ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.: 86
County of Washington Primary Registration District No. 1010
City of Weiser (No. East Commercial St.)
File No. 8405
Registered No. 34

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME L. J. Burns

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Sept. 10 1840 (Month) (Day) (Year)
7. AGE: 73 yrs. 10 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Brick mason
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Davis Co. Missouri
10. NAME OF FATHER: J. Burns
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: — Baxter
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs L. J. Burns
(Address): Weiser Ida
15.
Filed July 20 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) — 19 (Day) — 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 6 1914, to July 19 1914, that I last saw him alive on July 19 1914, and that death occurred on the date stated above, at 8 45 M.

The CAUSE OF DEATH* was as follows:
Chr. Bronchitis and Emphysema.
(Duration) Several yrs. mos. ds.
Contributory (Secondary) Hypostatic pulmonary congestion
(Duration) yrs. mos. 3 ds.
(Signed) Ernest O. Finney M. D.
July 19 1914 (Address) Weiser Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: July 21 1914
20. UNDERTAKER: R. W. Bowen — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 2112
City of Weiser (No. ....., ... St.)
File No. 8706
Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo M. Thomas.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Aug (Month) 6 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Weiser

10. NAME OF FATHER: Geo Thomas

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Essie McPhelridge

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G M Thomas
(Address) Weiser

15.
Filed Aug 6 1914 W.R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
..... 191....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191...., to ..... 191....
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cause unknown died Before Medical aid could Be Summoned
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James J Nelson M.D. Coroner
..... 19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Aug 6 191 4

20. UNDERTAKER: L.C. Northam — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 8202
Registered No. 36

1. PLACE OF DEATH.
County of Washington
City of Weiser (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Emma D. Draper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 18 (Day) 1869 (Year)

7. AGE: 45 yrs. 10 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spencer Iowa

10. NAME OF FATHER: Stephen Calkins

11. BIRTHPLACE OF FATHER (State or Country): State of Ill.

12. MAIDEN NAME OF MOTHER: Fc Wells

13. BIRTHPLACE OF MOTHER (State or Country): State of Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas C. Draper
(Address) Council Idaho

15. Filed Aug 29 1914 W. B. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1914, to Aug 24 1914, that I last saw h[illegible] alive on Aug 28 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Gret Prostrates
(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Cholangitis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S B Dredle M. D.
19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council Ida — DATE OF BURIAL: Aug 30 1914

20. UNDERTAKER: R. W. Brown — ADDRESS: Weiser, Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. ....., ... St.)

File No. 8708
Registered No. 3737

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nichols Beasley Brockman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Nov (Month) 14 (Day) 1841 (Year)

7. AGE: 72 yrs. 9 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: Nelson Brockman

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Ellen Clark

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John B. Brockman
(Address) Weiser Idaho

15.
Filed Aug 28 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Aug 27 1914, that I last saw him alive on Aug 26 1914 and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(mitral regurgitation)
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis and apoplexy
(Duration) 1 yrs. ..... mos. ..... ds.
(Signed) H. M. Mitchell M. D.
Aug 27 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Claysville Pa
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: L. C. Hoothorn
ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. ....., ... St.)

File No. 8709
Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Cookley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1863 (Year)

7. AGE: 51 yrs. 6 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Wm Stacy

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Verna Cookley
(Address) Weiser Ida

15.
Filed Sept. 3 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to 9-3 1914
that I last saw her alive on 9-3 1914
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows: Suicide by opening blood vessels of arm 4 hrs

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. B. Cheney M. D.
9-4 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida
DATE OF BURIAL: 9/5 1914

20. UNDERTAKER: L. L. Northam
ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 2112
(No. ....., ... St.)

File No. 8710
Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Willie Watkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH July — 22 — 1892
(Month) (Day) (Year)

7. AGE 22 yrs. 1 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Weiser Idaho

10. NAME OF FATHER W. H. Benson

11. BIRTHPLACE OF FATHER (State or Country) State of Minn.

12. MAIDEN NAME OF MOTHER Florence McFee

13. BIRTHPLACE OF MOTHER (State or Country) State of Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Benson
(Address) Weiser Idaho

15.
Filed Sept. 10 1914 W.P. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept — 9 — 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1914, to Sept 9 1914, that I last saw her alive on Sept 9 1914 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. N. Mitchell M. D.
Sept 11 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weiser Idaho	Sept. 11 1914

20. UNDERTAKER	ADDRESS
R. N. Bowen	Weiser Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 2 8[illegible]1
Registered No. 1

1. PLACE OF DEATH.
County of Twin Falls
City of Rock Creek (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin M. Crockett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. June 14 (Month) (Day) 1839 (Year)
7. AGE: 75 Yrs. 1 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Retired Farmer
9. BIRTHPLACE (State or Country) Maine
10. NAME OF FATHER David Crockett.
11. BIRTHPLACE OF FATHER (State or Country) Maine
12. MAIDEN NAME OF MOTHER Lydia Young
13. BIRTHPLACE OF MOTHER (State or Country) Maine
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. D. Crockett
(Address) Rock Creek, Idaho
15. Filed July 30 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 29 (Month) (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 6 1914, to July 9 1914, that I last saw h[illegible] alive on July 9 1914 and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Gastric Carcinoma
.....(Duration) ..... Yrs. 3 mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
July 30 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rock Creek. DATE OF BURIAL: July 30 1914
20. UNDERTAKER: C. J. Crosby ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

File No. .....
Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Philippa Hamley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1832 (Year)

7. AGE: 82 yrs. 4 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Birch

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: ____ Johns

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.G. Rothwell MD
(Address) Kendrick Idaho.

15. Filed July 24 1914 J.E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 23. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14. 1913. to July 23rd 1914 that I last saw h[er] alive on July 23rd 1914 and that death occurred on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:
Progressive Paralysis
..... (Duration) ..... yrs. 9 mos. 9 ds.
Contributory Acute Bronchitis
(Secondary)
..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W.G. Rothwell M. D.
July 24th 1914 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kendrick Idaho. DATE OF BURIAL: July 25. 1914

20. UNDERTAKER: U.S.G. Evans ADDRESS: Kendrick Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

File No.

County of Boise

City of Roseberry (No. , St.)

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Batana A. Becker.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: I (Month) I8 (Day) 1866 (Year)

7. AGE: 48 yrs. 3 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry business, or dstablishment in which employed (or employer): for husband.

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: David Day.

11. BIRTHPLACE OF FATHER (State or Country): Don't Know.

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Becker.

(Address) Roseberry Idaho

15.

Filed July 20 1914 Emma E. McKinley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

(No Physician)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Holmes Cemetery

DATE OF BURIAL: ....191...

20. UNDERTAKER: Casket procured from D.M.Cox

ADDRESS: Roseberry.

SYMS - YORK CO., PTRS. & BDRS. 19760

Right of JURISDICTION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... , ... St.)

File No. 8714
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Franson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH Do not Know 1
(Month) (Day) (Year)

7. AGE 60 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Do not Know

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Wanson
(Address) Rexburg

15. Filed 8-13 1914 G H Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 8 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1914, to Aug 11 1914, that I last saw h[illegible] alive on Aug 11 1914, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) J Wanson M. D.
1914 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg — DATE OF BURIAL 8/13 1914

20. UNDERTAKER J Young — ADDRESS Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 8715
Registered No. 32
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Norman H. Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Jan (Month) 4 (Day) 1881 (Year)

7. AGE
33 yrs. 7 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Morgan Co Utah

10. NAME OF FATHER James H. Mason

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Pamela - Bulloh

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas E Mason
(Address) Parker

15. Filed 8-19 1914 G.G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
8 (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1914, to Aug 16 1914, that I last saw him alive on Aug 16 1914, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Septicemia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Walker M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parker	8/20 1914

20. UNDERTAKER J Wyatt — ADDRESS Ryby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 8716
Registered No. 33

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Austin C. Porter

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Child

6. DATE OF BIRTH: Aug (Month) 14 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 5 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baker
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rexburg

10. NAME OF FATHER: Arthur Porter Jr.

11. BIRTHPLACE OF FATHER (State or Country): New Zeland

12. MAIDEN NAME OF MOTHER: Nell - Child

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Porter, Jr.
(Address) Rexburg

15. Filed 8-23 1914
G. G. Capps
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-14 1914, to 8-18 1914, that I last saw h-- alive on 8-18 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. G. Capps M. D.
19 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 8-19 1914

20. UNDERTAKER: J. Ryorg
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... , ... St.)

File No. 8711
Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Madison
City of Sugar

If death occurs away from usual residence, give facts called for under special information. 8/28/14

2. FULL NAME Kisuke Asano

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March (Month) ..... (Day) 1913 (Year)

7. AGE: 1 Yrs. 5 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER K. Asano

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER B. Otsuki

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Sugar City, Ida.

15.
Filed 8-29 1914
G. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowned (accidental)

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) none M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 8/29 1914

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

STAR - YORK CO., PTGS. & ENGS. 24656

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. .....

Primary Registration District No. 2

(No. ....., ... St.)

File No. .....

Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME L. Lodesani

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ? (Write the word.)

6. DATE OF BIRTH. ? — — — 1 (Month) (Day) (Year)

7. AGE: About 30 years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: — ?

(b) General nature of industry, business, or establishment in which employed (or employer): — ?

9. BIRTHPLACE (State or Country): — ?

10. NAME OF FATHER: — ?

11. BIRTHPLACE OF FATHER (State or Country): — ?

12. MAIDEN NAME OF MOTHER: — ?

13. BIRTHPLACE OF MOTHER (State or Country): — ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. W. Muhlenan

(Address) I. Falls.

15. Filed Sept 16 1914

Local Registrar

6YMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1914, to Sept. 6, 1914, that I last saw h~~a~~m alive on Sept. 6, 1914 and that death occured on the date stated above, at 4a.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) Indefinite Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) John W. Mellen M. D.

19.. (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: 9-16 1914

20. UNDERTAKER: Thos. W. Muhlenan — ADDRESS: I. Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8719

Registered No. 92

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of I. Falls

(No. ..... St.)

Registration District No. 3

Primary Registration District No. 214-0

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank A. Sanders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 11 (Day) 1840 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: ✓ ?

11. BIRTHPLACE OF FATHER (State or Country): ✓ ?

12. MAIDEN NAME OF MOTHER: ✓ ?

13. BIRTHPLACE OF MOTHER (State or Country): ✓ ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Sanders

(Address) Idaho Falls

15.

Filed Sept 12 1914

Local Registrar

SYMS - YORK CO. PTG. & BOOK. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,

that I last saw h... alive on — 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

General Debility & old age

No Physician in attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

9/12 19.. (Address) County Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: 9-11-1914

20. UNDERTAKER: Thos. W. Muhlestein — ADDRESS: I. Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8120

Registered No. 91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. [illegible]

(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nephi Clifford Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feby. 13 1904
(Month) (Day) (Year)

7. AGE: 10 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Heber City Utah

10. NAME OF FATHER: Ira Smith

11. BIRTHPLACE OF FATHER (State or Country): Heber City, Utah

12. MAIDEN NAME OF MOTHER: Sarah E. Moulton

13. BIRTHPLACE OF MOTHER (State or Country): Heber City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ira L. Smith
(Address) Idaho Falls

15. Filed Sept 6 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 3 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 191[illegible], to [illegible] 191[illegible], that I last saw him alive on Sept. 3 1914, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Accidental (Kicked by horse)

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Contusion

(Duration) yrs. mos. 4 ds.

(Signed) A R Sederquist M. D.

9/5 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 9/6 1914

20. UNDERTAKER: C C Linwoodey — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 2 6
File No. .....
Registered No. 90

1. PLACE OF DEATH.
County of Idaho Falls
City of Bonner Alg
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willie Perkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 3 (Day) 1914 (Year)

7. AGE: X Yrs. 1 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pendleton Oregon.

10. NAME OF FATHER Thomas Perkins

11. BIRTHPLACE OF FATHER (State or Country) Kentucky.

12. MAIDEN NAME OF MOTHER Anna Radcliff

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos. Perkins
(Address) Idaho Falls Ida.

15. Filed Sept 3 1914 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Malnutrition
Died without care of a
Physician
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Geo. Marley Gorrey M. D.
9/3 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls — DATE OF BURIAL: 9-3-1914

20. UNDERTAKER: Thos. A. Muhleman — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-17
File No. 8122
Registered No. 67

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel H McLean

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH. Aug (Month) 17 (Day) 1850 (Year)

7. AGE: 64 Yrs. X Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: S. A. McLean

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Anava Hughes

13. BIRTHPLACE OF MOTHER (State or Country): U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George T. McLean
(Address) Bone Idaho

15. Filed Sept 191[illegible]
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1914, to Aug 27 1914, that I last saw h[illegible] alive on Aug 27 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Gangrene Senile

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Sept 19 14 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 8/29 1914

20. UNDERTAKER: C. C. Linwood — ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 23

Primary Registration District No. 2170

(No. ....., ... St.)

File No. 814

Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Ellen Newman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Mch. (Month) 26 (Day) 1914 (Year)

7. AGE: ..x.. Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho Falls, Ida

10. NAME OF FATHER: Alma Newman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ellen Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alma Newman

(Address) Idaho Falls, Ida

15. Filed Sept. 1914

Local Registrar

SVMS - YORK OFF. PTRS. & BOOK. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 191.., to Aug 31 1914, that I last saw h er alive on Aug 30 1914, and that death occured on the date stated above, at 8:30 a.M.

The CAUSE OF DEATH* was as follows: Inflamation of Bowels

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) S. E. Fuller M. D.

9/1 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milo, Idaho — DATE OF BURIAL: 9/2 1914

20. UNDERTAKER: C. E. Linwoodey — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 872

Registered No. 67

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls. (No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 2150

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfred H. Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 4 (Day) 1844 (Year)

7. AGE: 70 Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Contractor

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Neal

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anna Corson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary J. Neal.

(Address) Idaho Falls. Idaho

15. Filed Aug 29 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191..., that I last saw h ✓ alive on ✓ 191..., and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

sudden

..... (Duration) ✓ Yrs. ✓ mos. ✓ ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. H. Heyburn M. D.

Aug 29 1914 (Address) Idaho Falls. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Lawn Cemetery — DATE OF BURIAL: 8-30- 1914

20. UNDERTAKER: Thos. W. Murphy — ADDRESS: Id. Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTGS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8726

Registered No. 151

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. .... St.)

Registration District No. 73

Primary Registration District No. 2150

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen B Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.: April (Month) x (Day) 1893 (Year)

7. AGE: 21 Yrs. 5 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Alma Jensen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lovina Cox

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alma Jensen
(Address) Idaho Falls, Ida

15. Filed Sept 9 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1914, to Sept 7 1914, that I last saw her alive on Sept 7 1914, and that death occured on the date stated above, at 7P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Fuller M. D.

9/9 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland (Blackfoot, Ida) — DATE OF BURIAL: 9/9 1914

20. UNDERTAKER: C. C. Linwood — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6704

Registered No. 27

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2-3

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Justus G. Fardyce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 1 (Day) 1842 (Year)

7. AGE: 72 Yrs. — Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pa

10. NAME OF FATHER: James Harvey Fardyce

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bert M. Wilson

(Address) Idaho Falls

15. Filed Sept 3 1914 Geo. Hammond Local Registrar

SYMS - YORK CO., PRTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 3 1914, to Sep 3 1914, that I last saw h[illegible] alive on Sep 3 1914 and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. Gaddis M. D.

19 14 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Washington Iowa — DATE OF BURIAL: Shipped

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8728

Registered No. 83

1. PLACE OF DEATH.

County of Bannock

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 211-0

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lora Ann Conley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 20 (Day) 1871 (Year)

7. AGE: 46 Yrs. 11 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Thomas Warfield

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Margaret Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. M. Conley

(Address) Idaho Falls Idaho

15. Filed Aug 21 1914 C. E. Hunt Local Registrar

SYMS - YORK CO. PTRS. & ROBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Aug 21 1914, that I last saw her alive on Aug 21 1914, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Hunt M. D.

8/21 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lincoln Ill. DATE OF BURIAL: Aug 24 1914

20. UNDERTAKER: J. H. Hunt ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

Primary Registration District No. 2150

File No. [illegible]

County of Bonneville

City of Iona (No. ....., ... St.)

Registered No. [illegible]

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl S. Olsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Widowed (write the word.)

6. DATE OF BIRTH

Dec. (Month) 10th. (Day) 1830 (Year)

7. AGE

83 yrs. 8 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Risor, Norway

10. NAME OF FATHER Ole Thoresen Olsen

11. BIRTHPLACE OF FATHER (State or Country) Risor, Norway

12. MAIDEN NAME OF MOTHER Guri Aslakdater

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Olsen

(Address) Iona, Ida.

15. Filed Aug 3 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1st 1914, to ..... 191..., that I last saw him alive on Aug 1st. 1914, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Sunstroke

(Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. R. Soderquist M. D.

Aug 15 1914 (Address) Idaho Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ovid, Idaho.	8/17/14 191..

20. UNDERTAKER	ADDRESS
C. E. Dinwoodey	Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Fish Haven
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53
Primary Registration District No.
(No. , St.)
File No.
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Frances Findlay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
March (Month) 31 (Day) 1862 (Year)

7. AGE
52 yrs. 5 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wife and Mother
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Salt Lake City Utah

10. NAME OF FATHER Henry Howell

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Frances Goble

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Wm Findlay
(Address) Fish Haven Idaho

15.
Filed 191
John Mattson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept 2 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191,
that I last saw h alive on 191,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Intestinal obstruction
(Duration) yrs. mos. 3 ds.
Contributory (Secondary) umbilical hernia
? (Duration) — yrs. — mos. — ds.
(Signed) A P Cooley M. D.
19 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos..days. In the State ..yrs..mos..days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fish Haven Idaho | DATE OF BURIAL: Sept 4 1914
20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 69731

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8[illegible]

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham

City of Shelley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. 2147

(No. ....., ... St.)

2. FULL NAME Kenneth Humphreys

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Oct 22 1905 (Month) (Day) (Year)

7. AGE: 8 Yrs. 10 Mos. 18 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Shelley Ida

10. NAME OF FATHER S.S. Humphreys

11. BIRTHPLACE OF FATHER (State or Country) Paris Ida

12. MAIDEN NAME OF MOTHER Ida M Smedley

13. BIRTHPLACE OF MOTHER (State or Country) Delaware

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S.S. Humphreys
(Address) Shelley Ida

15.
Filed 9-12-1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 10 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11AM. 9-10-1914, to 6PM. 9-10-1914, that I last saw him alive on 9-10-1914, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

.....(Duration) .....Yrs. .....mos. 1 ds.

Contributory (Secondary) Accidental burns on legs.

.....(Duration .....yrs. .....mos. 1 ds.

(Signed) Edwin Cutler M. D.

9-12 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley Ida — DATE OF BURIAL: 9/13/1914

20. UNDERTAKER: C E Dunwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8732
Registered No.

1. PLACE OF DEATH.
County of Bingham
City of Woodville

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Jayann

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 8 (Month) – 17 (Day) – 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 1 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Woodville Ida

10. NAME OF FATHER: Geo. R Jayann

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Tora Jorgenson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): G. R. Jayann
(Address): R #4 Idaho Falls.

15. Filed 8-17-1914 Edwin Cutler, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) – 17 (Day) – 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-17-1914, to 8-17-1914 that I last saw h.. alive on 8-17-1914 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Premature birth
and defective development

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Cutler M. D.
8-17-1914 (Address) R#4. Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Woodville Cemetery
DATE OF BURIAL: 8-17-1914

20. UNDERTAKER: None
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham
City of Basalt

Registration District No. 69
Primary Registration District No. 2147
(No. ..... St.)

File No. 3
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leola May Hoover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. April (Month) 20 (Day) 1907 (Year)

7. AGE: 10 Yrs. 8 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Clarence Hoover

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Unice Katherine Pitchford

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Katie Hoover
(Address) Shelley Idaho

15. Filed 8-4-1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1914, to Aug 4 1914, that I last saw h.e alive on Aug 3 1914 and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. M. Shute M. D.

8/4 1914 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Basalt Idaho — DATE OF BURIAL: 8-5-1914

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & ROBS. 24858

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 69

County of Bingham Primary Registration District No. 247

City of Shelley (No. ....., ... St.)

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velta Wadsworth

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH May (Month) 16 (Day) 1912 (Year)

7. AGE 2 yrs. 3 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... At home
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Shelley Idaho.

10. NAME OF FATHER Arnold Wadsworth

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Sarah Humphreys

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phyllis Mitchell
(Address) Shelley Idaho

15. Filed 8-29 1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw h— alive on — 191...
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Drowning

(Duration) 2 yrs. 3 mos. 13 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edwin Cutler M. D.
8-29- 1914 (Address) Shelley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Shelley Cemetery DATE OF BURIAL 8-29-1914

20. UNDERTAKER None ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Shelley

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

File No. 843

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velma Chadwick.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 24 (Day) 1914 (Year)

7. AGE: 8 yrs. 5 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Shelley, Ida.

10. NAME OF FATHER: Jas Chadwick

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Pritchard

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Chadwick
(Address) Shelley, Ida.

15. Filed 8-20-1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 19 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-18-1914, to 8-19-1914
that I last saw h.. alive on 8-19-1914
and that death occurred on the date stated above, at 2P.M.
The CAUSE OF DEATH* was as follows:
Gangrenous Appendicitis
..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edwin Cutler M. D.
8-20 1914 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Shelley Hospital In the
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, ...
If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery
DATE OF BURIAL: 8-20-1914

20. UNDERTAKER: none
ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Shelley

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph L. Holst

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 30 (Day) 1911 (Year)

7. AGE: 3 yrs. 2 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Shelley Idaho

10. NAME OF FATHER: John H. Holst,

11. BIRTHPLACE OF FATHER (State or Country): Utah,

12. MAIDEN NAME OF MOTHER: Emma J. Christensen

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Holst
(Address) Shelley Idaho

15.
Filed 7-21-1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914., to July 20 1914
that I last saw h[im] alive on July 20. 1914
and that death occurred on the date stated above, at 7:35 P.M.

The CAUSE OF DEATH* was as follows:
Membranous Croup.
.....
.....
..... (Duration) ..... yrs. ..... mos. 3d ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Cutler M. D.
7-21-1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery
DATE OF BURIAL: 7-21-1914

20. UNDERTAKER: .....
ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 69
Primary Registration District No. 2147
File No. 7
Registered No. .....

1. PLACE OF DEATH.
County of Bingham
City of Woodville
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gotfried Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Color.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ~~Oct 25 1876~~ July 29 1914 (Month) (Day) (Year)

7. AGE ~~37~~ ~~37~~ Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Stockholm Sweden

10. NAME OF FATHER Claus Johnson

11. BIRTHPLACE OF FATHER (State or Country) Stolkholm Sweden

12. MAIDEN NAME OF MOTHER Katherine Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Stockholm Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur Burke
(Address) Idaho Falls Idaho

15. Filed July 29 1914 Edwin Cutler M.D. Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1914, to July 29 1914, that I last saw him alive on July 28 1914, and that death occured on the date stated above, at 12 3/4 M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
.....
.....
(Duration) ..... Yrs. ..... mos. 30 ds.
Contributory (Secondary) Abcess of Lungs
(Duration) ..... Yrs. ..... mos. 15 ds.
(Signed) F. W. Roberts M. D.
7/29 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery — DATE OF BURIAL: 7-30-1914

20. UNDERTAKER: C. E. Dunwoody — ADDRESS: Idaho Falls

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8738
Registered No.

1. PLACE OF DEATH.
County of Bingham
City of Woodville

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John G. Everett.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Sept. (Month) 27 (Day) 1821 (Year)

7. AGE: 92 yrs. 9 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany (Prussia)

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Everett
(Address) Idaho Falls Rt 2

15.
Filed 7-21 1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-16 1914, to 7-19 1914
that I last saw him alive on 7-19 1914
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Senility
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edwin Cutler M. D.
7-21 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Idaho Falls Cemetery
DATE OF BURIAL: 7-22 1914

20. UNDERTAKER: C. E. Dinwoodey
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Shelley

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)
File No. (illegible)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola Smith.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 24 (Day) 1913 (Year)

7. AGE: 1 yrs. 1 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe at home
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Shelley Idaho

10. NAME OF FATHER: Frank Smith

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Myrtle Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Smith
(Address) Shelley Idaho

15.
Filed July 3 - 1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 2d (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1914, to July 2d 1914
that I last saw her alive on July 2d 1914
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. 3d ds.
Contributory (Secondary) Whooping Cough
(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) Edwin Cutler M. D.
7 - 2 1914 (Address) Shelley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Shelley Idaho
DATE OF BURIAL: 7 - 3 1914

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8411

Registered No.

1. PLACE OF DEATH.
County of Bingham
City of Basalt

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clifton Wommack

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: 7 (Month) 3 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..2.. hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ax Thrower
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm J. Wommack

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Edna M Crofts

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm J. Wommack
(Address) Basalt

15.
Filed 7-4 1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 1914, to Death 1914
that I last saw he alive on ..... 191....
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:
Premature birth.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edwin Cutler M. D.
..... 19.... (Address) Basalt Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basalt Cemetery
DATE OF BURIAL: ..... 191....

20. UNDERTAKER: None
ADDRESS:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AVIS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 69
County of Bingham Primary Registration District No. 2147
City of Shelley (No. ....., ... St.)
File No. 8712
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurine Cutler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 22 1913 (Month) (Day) (Year)

7. AGE: 2 yrs. 2 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Shelley Idaho

10. NAME OF FATHER: Edw. H. Cutler

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Myrtle Thorne

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin H. Cutler
(Address) Shelley, Idaho

15. Filed 6-27-1914 Edw. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 26 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-1-1914, to 6-26-1914 that I last saw her alive on 6-26-1914 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Bronch Pneumonia

..... (Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) Whooping Cough.

..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Edwin Cutler M. D.

6-27 1914 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery — DATE OF BURIAL: 6-28 1914

20. UNDERTAKER: C. E. Dunworth — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, SO136 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8744

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Shelley

Registration District No. 67

Primary Registration District No. 2147

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hyram Lamar Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. 1st (Month) (Day) 1913 (Year)

7. AGE: ..... Yrs. 6 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hyram Cooper

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Liggie Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hyram Cooper

(Address) Shelley Idaho

15. Filed 6-16-1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1914, to June 15 1914, that I last saw h[illegible] alive on June 14 1914, and that death occured on the date stated above, at 12 15 M.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Gibbs M. D.

6/15/1914 (Address) Shelley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley — DATE OF BURIAL: 6-17-1914

20. UNDERTAKER: — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69

Primary Registration District No. 2147

File No. [illegible]

County of .....

City of .....

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. June (Month) 24 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lewis Christensen

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Jennie McBride

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Holger Christensen

(Address) Shelley

15. Filed 6-25-1914

E Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1914, to June 24 1914, that I last saw h[illegible] alive on June 24 1914, and that death occured on the date stated above, at 10:15 P.M.

The CAUSE OF DEATH* was as follows:

Infant of 2 days

6 hrs. Retention

and Placenta Previa

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Cutler M. D.

June 25 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery — DATE OF BURIAL: 6-25-1914

20. UNDERTAKER: Moore — ADDRESS

BYNS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 69

County of Jamestown Primary Registration District No. 2147

City of Jamestown (No. ....., ... St.)

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Aline Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	White	Single

6. DATE OF BIRTH

Nov. (Month) 13th (Day) 1913 (Year)

7. AGE

1 yrs. 5 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... At home

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Jamestown, Idaho,

10. NAME OF FATHER Tempest Robinson

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Nellie Pearl Dotty

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tempest Robinson R.F.D.

(Address) Shelley Idaho

15.

Filed 5-11- 1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5 (Month) - 10 (Day) - 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-1-1914, to 5-10-1914, that I last saw h.m alive on 5-9-1914 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Malnutrition all her life.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Cutler M. D.

19 (Address) Shelley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Tailor Idaho	5-12-1914
20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8417
Registered No.

1. PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alta Jane Hull Korhen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug. 28 (Month) 1892 (Day) (Year)

7. AGE: 21 yrs. 8 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley, Bingham Co. Ida.

10. NAME OF FATHER: Thos. M. Hull

11. BIRTHPLACE OF FATHER (State or Country): Cache Valley Utah.

12. MAIDEN NAME OF MOTHER: Julina Fredrica Rasmussen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. F. Korhen
(Address) Shelley Idaho

15.
Filed 5-20 1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) - 18 (Day) - 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-17-1914, to 5-18 1914 that I last saw h[illegible] alive on 5-18-1914 and that death occurred on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:
Endocarditis

..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Worry and weakness following childbirth
..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Edwin Cutler M. D.
5-20-1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley
DATE OF BURIAL: 5-20-1914

20. UNDERTAKER: None employed
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Basalt

Registration District No. 67
Primary Registration District No. 2147
(No. ....., ... St.)

File No. 548
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norman Erastus Freeman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 27 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baker
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Basalt-Idaho

10. NAME OF FATHER: Erastus Bingham Freeman

11. BIRTHPLACE OF FATHER (State or Country): St. Johns Arizona

12. MAIDEN NAME OF MOTHER: Selina Josephine Graves

13. BIRTHPLACE OF MOTHER (State or Country): Mink Creek Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Erastus B. Freeman
(Address) Basalt Idaho

15. Filed 5-28-1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1914, to May 28 1914 that I last saw him alive on May 27 1914 and that death occurred on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:
Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Difficult Labor in delivery

..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edwin Cutler M. D.
5-28 1914 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basalt Idaho
DATE OF BURIAL: 5-28 1914

20. UNDERTAKER: .....
ADDRESS: .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69

County of Bingham

Primary Registration District No. 2147

File No. [illegible]

City of Bardlet

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Enos Forgenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 14 (Day) 1879 (Year)

7. AGE: 35 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Enos Forgenson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Harriet Sandberg

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Israel H. Porter

(Address) Shelley R. F. D. # 2.

15. Filed April 2 1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 27 1914, to Apr 2 1914, that I last saw him alive on April 2 1914, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Roberts M. D.

4/5 1914 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basalt — DATE OF BURIAL: April 4 1914

20. UNDERTAKER: None employed — ADDRESS:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Woodville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 69

Primary Registration District No. 2147

(No. ..... , ... St.)

File No. .....

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Heber Mathews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Feb. (Month) 12 (Day) 1858 (Year)

7. AGE

56 yrs. 1 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah.

10. NAME OF FATHER William Mathews

11. BIRTHPLACE OF FATHER (State or Country) Eng.

12. MAIDEN NAME OF MOTHER Jane Mathews

13. BIRTHPLACE OF MOTHER (State or Country) Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Frank Mathews

(Address) R.D.# 4 Idaho Falls

15.

Filed 4-7-1914 Edwin Coulter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-25- 1914, to 4-7- 1914, that I last saw h.im alive on 4-3- 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) Hard work & Alcoholism all his life.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Coulter M. D.

4-7-1914 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	4-9 1914

20. UNDERTAKER	ADDRESS
Jos. Morley	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. .....

County of Bingham

Primary Registration District No. .....

File No. .....

City of Gorham

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anita Hattie Olsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W.	Single

6. DATE OF BIRTH Feb. March 26 1914
(Month) (Day) (Year)

7. AGE ..... yrs. 1 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Baby
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Goshen Idaho

10. NAME OF FATHER Christian Olsen

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Harriet J. Sessions,

13. BIRTHPLACE OF MOTHER (State or Country) Afton Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R # 1 Shelley
(Address) Celia T. Sessions

15.
Filed 4 - 2 - 1914 Edwin MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 4 - 1 - 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Indigestion

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature birth.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) No later employed. M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Goshen — DATE OF BURIAL: 4-3-1914

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Shelley

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

File No. 8[illegible]
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Iris Lucetta Stoddard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 3 (Month) - 27 (Day) - 1906 (Year)

7. AGE: 7 yrs. 11 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Jailor, Idaho

10. NAME OF FATHER: Jos. F Stoddard

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Margrett V. Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph F. Stoddard
(Address) Jailor, Idaho

15.
Filed 3-7 1914
Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 6 (Day) - 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-2-1914, to 3-6-1914
that I last saw her alive on 3-6-1914
and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:
Gangrenous Appendicitis
..... (Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) none
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edwin Cutler M. D.
3-6-1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jailor
DATE OF BURIAL: 3-8 1914

20. UNDERTAKER: C. E. Dunwoody
ADDRESS: Idaho Falls.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69

County of

Primary Registration District No. 2147

File No. 8753

City of (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Verna Linn Mace

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	married

6. DATE OF BIRTH: Feb (Month) 27 (Day) 1874 (Year)

7. AGE: 40 yrs. mos. 19 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Fletcher

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Flesher

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Mace
(Address) Shelley

15. Filed 3-19 1914. Edwin Cutler, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1914, to Mch 18 1914, that I last saw her alive on Mch. 18 1914, and that death occurred on the date stated above, at 2.20 M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) — yrs. one mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. E. Gilbert M. D.

3/18 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls. DATE OF BURIAL: 191

20. UNDERTAKER: G. H. Hunt ADDRESS: Idaho Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Brigham
City of Shelley

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Terry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	White	Single

6. DATE OF BIRTH Feb. 16 — 1914
(Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 4 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Baby
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Shelley Idaho

10. NAME OF FATHER Chas. O. Terry

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Elvira Campbell

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas O. Terry
(Address) Shelley Idaho

15.
Filed 2-19-1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2 - 18 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Shelley — DATE OF BURIAL 2-19-1914

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 69
Primary Registration District No. 2147
File No. 8756
Registered No. ____

1. PLACE OF DEATH.
County of Bingham
City of Shelley.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Goldie Leona Mace.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: She
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. Jan. (Month) 5 (Day) 1898 (Year)
7. AGE: 16 Yrs. 1 Mos. 15 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... At home.
(b) General nature of industry, business, or establishment in which employed (or employer)....
9. BIRTHPLACE (State or Country) Iowa
10. NAME OF FATHER W.A. Mace
11. BIRTHPLACE OF FATHER (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Verna Fletcher
13. BIRTHPLACE OF MOTHER (State or Country) Minisota
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. A. Mace
(Address) Shelley Idaho
15. Filed 2 — 21 1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 20 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 7 1914, to Feb. 20 1914, that I last saw her alive on Feb. 20 1914, and that death occured on the date stated above, at 9:30 A. M.
The CAUSE OF DEATH* was as follows:
Typhoid fever
(Duration) ____ Yrs. ____ mos. 16 ds.
Contributory (Secondary) ✓
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) F. E. Gilbert M. D.
2/20 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls — DATE OF BURIAL 2/21 1914
20. UNDERTAKER G. H. Hunt — ADDRESS Idaho Falls

SYMS - YORK CO., PTRS. & BKBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Shelley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 67
Primary Registration District No. 2147
(No. ....., ... St.)

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laurence Myrle Tuttle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH: 9 (Month) – 13 (Day) 1913 (Year)

7. AGE: ..... yrs. 4 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Goshen Idaho

10. NAME OF FATHER: Jacob Tuttle

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Elsie J. Whitmill

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob J. Tuttle
(Address) Shelley, Idaho.

15.
Filed 1 – 14 – 1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1914, to Jan 13 1914, that I last saw h— alive on Jan 12 1914 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Bron. Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F E Roberts M. D.
1-13 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Goshen Idaho
DATE OF BURIAL: 1 – 15 – 1914

20. UNDERTAKER: —
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 69

County of Bonneville

Primary Registration District No. 2147

City of Shelley

(No. ..... St.)

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilma Hurst

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Infant

6. DATE OF BIRTH

1 (Month) 2 (Day) 1914 (Year)

7. AGE

..... yrs. ..... mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Infant

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Creighton Hurst

11. BIRTHPLACE OF FATHER (State or Country) Idaho Utah.

12. MAIDEN NAME OF MOTHER Mary E. Mitchell

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Creighton Hurst

(Address) Woodville

15.

Filed 1 — 6 1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1 — 4 — 1914, to 1 — 5 — 1914 that I last saw her alive on 1 — 5 — 1914 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Accident & Injuries

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Cutler M. D.

1-6-1915 (Address) Shelley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodruff	1 — 6 1914

20. UNDERTAKER	ADDRESS
None employed	—

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Presb

Registration District No. 69
Primary Registration District No. 2147
(No. ....., ... St.)

File No. 8460
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Collings

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Single

6. DATE OF BIRTH: 1 (Month) — 27 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work — — —
(b) General nature of industry business, or establishment in which employed (or employer) — —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. A. Collings

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Emma Thurston

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Collings
(Address) Presb. Ida.

15.
Filed 1 — 28 1914 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-27-1914 to 1-27-1914 that I last saw h[illegible] alive on 1-27-1914 and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Cutler M. D.
1/27 1914 (Address) Shelley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Goshen	1-28 1914

20. UNDERTAKER	ADDRESS
None Employed	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Shelley (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 69
Primary Registration District No. 2147

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Yorgeson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W.	Single

6. DATE OF BIRTH
May (Month) 23. (Day) 1913 (Year)

7. AGE
..... yrs. 7 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... At home
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Shelley Ida

10. NAME OF FATHER Alonzo S. Yorgeson

11. BIRTHPLACE OF FATHER (State or Country) Fountain Green Utah

12. MAIDEN NAME OF MOTHER Effie Hall.

13. BIRTHPLACE OF MOTHER (State or Country) Beven Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. S. Yorgeson Sr.
(Address) Shelley Idaho

15.
Filed 1-13 1914 Edwin Leuter M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 13. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-8- 1914, to 1-13- 1913, that I last saw her alive on 1-13- 1913 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Chicken Pox
..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Edwin Leuter M. D.
1-13-1914 (Address) Shelley Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Shelley Idaho	1-14-1914

20. UNDERTAKER	ADDRESS
None	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Firth
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 69
Primary Registration District No. 2147
(No. ..... St.)

File No.
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John A. Robertson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	W.	Married

6. DATE OF BIRTH: Dec. (Month) 29 (Day) 1844 (Year)

7. AGE: 69 yrs. 5 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Glasgow Scotland

10. NAME OF FATHER: Alexander Robertson

11. BIRTHPLACE OF FATHER (State or Country): Glasgow Scotland

12. MAIDEN NAME OF MOTHER: Agnes Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Paisley Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex Robertson
(Address) Firth Idaho

15. Filed 2-1 1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31 1913, to Jan 3 1914, that I last saw h- alive on Jan 2 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
General Paralysis
from Fatty Heart
& Kidney action.
(Duration) 6 yrs. 1 mos. ds.
Contributory (Secondary) old age
(Duration) yrs. mos. ds.
(Signed) F. E. Gilbert M. D.
Jan 4 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Firth Idaho	1-5 1914

20. UNDERTAKER	ADDRESS
D. Beeton	Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N, B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

5421. Dr Newton.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 528, East Hayden St.)

File No. 5
Registered No. 204
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Martha Koury

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Assyrian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): ~~(Write the word)~~

6. DATE OF BIRTH: July (Month) 3 (Day) 1914 (Year)

7. AGE: ——yrs. ——mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Alias Koury

11. BIRTHPLACE OF FATHER (State or Country): Syria

12. MAIDEN NAME OF MOTHER: Vergene Bolos

13. BIRTHPLACE OF MOTHER (State or Country): Syria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Ida Koury
(Address): Pocatello Idaho

15. Filed July 25 1914 — O. F. Smith, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/3 1914, to 7/23 1914
that I last saw h[illegible] alive on 7/2[illegible] 1914,
and that death occurred on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:
Enteritis-colitis

(Duration) ——yrs. 1 mos. ——ds.

Contributory (Secondary)

(Duration) ——yrs. ——mos. ——ds.

(Signed) Dr A. M. Newton M. D.
July 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ——yrs. ——mos. ——ds. In the State ——yrs. ——mos. ——ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: July 25 1914

20. UNDERTAKER: Wallace & Wann — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City or Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. 536 W Lander St.)

File No. 5-[illegible]

Registered No. 206

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Infant) Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Aug (Month) 7 (Day) 1914 (Year)

7. AGE: ... Yrs. ... Mos. 1 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Delbert Hansen

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Frances Barrett

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Delbert Hansen

(Address) 536 W Lander

15. Filed Aug 8th 1914

[illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1914, to Same 1914, that I last saw him alive on Aug 7th 1914, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) ... Yrs. ... mos. 1 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) L M Sprague M. D.

8-10 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Aug 8 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 646, North Hayes St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161

File No. 5
Registered No. 207
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lilah Grace Cullen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Sept. (Month) 30 (Day) 1912 (Year)

7. AGE: 1 yrs. 11 mos. 8 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: James F. Cullen

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Botilla Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James F. Cullen
(Address) Pocatello Idaho

15.
Filed Aug 9 1914 O. P. Tracy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25th 1914, to Aug 8th 1914, that I last saw her alive on Aug 8th 1914, and that death occurred on the date stated above, at 6 a.m. M.

The CAUSE OF DEATH* was as follows:
Entero-Colitis

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O. P. Tracy M. D.
Aug 9 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 8/11 1914

20. UNDERTAKER: Wallace — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Dr Sprague.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 54
County of Bannock Primary Registration District No. 2161 File No. 5
City of Pocatello (No. 935, North Main St.) Registered No. 209
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Lois Pearl Dean
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 25 (Day) 1914 (Year)

7. AGE: 2 yrs. 3 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Butte Mont.

10. NAME OF FATHER: Geo. S. Dean

11. BIRTHPLACE OF FATHER (State or Country): Ogden Utah

12. MAIDEN NAME OF MOTHER: Dollie Pearl Wrathman

13. BIRTHPLACE OF MOTHER (State or Country): Albion Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo S Dean
(Address) 935 No. Main

15. Filed Aug 9 1914 O J Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1914, to Aug 8 1914 that I last saw her alive on Aug 7 1914, and that death occurred on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:

Infantile Atrophy

(Duration) yrs. 2 mos. ds.

Contributory (Secondary): Enteritis feeding

(Duration) yrs. 2 mos. ds.

(Signed) L M Sprague M. D.

Aug 9 1914 (Address) Dietrich Block

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Aug 9 1914

20. UNDERTAKER: Wallace & Sons — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5

Registered No. 209

1. PLACE OF DEATH. Registration District No. 8 4

County of Bannock Primary Registration District No. 2161

City of Pocatello (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME W D Telas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	white	

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work No
(b) General nature of industry business, or establishment in which employed (or employer) None

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Aug 11 1914 O B Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1914, to Aug 10 1914

that I last saw him alive on Aug 9 1914,

and that death occurred on the date stated above, at 12:30 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 1 yrs. 4 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr A M Newton M. D.

Aug 12 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. View Potters field	Aug 20 1914
20. UNDERTAKER	**ADDRESS**
Wallace & Mann	Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5

Registered No. 210

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
Registration District No. 84
Primary Registration District No. 2161
(No. 626, N. Eighth Ave. St.)

2. FULL NAME Florence Caroline Sage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: July (Month) 18 (Day) 1909 (Year)

7. AGE: 5 yrs. — mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wyoming

10. NAME OF FATHER N. J. Sage

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Joanna Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H J Sage
(Address) Sheridan Wyo

15. Filed Aug 12 1914 O J Tuely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1914, to Aug 12 1914, that I last saw h[illegible] alive on Aug 11 1914, and that death occurred on the date stated above, at 4:25 P.M.

The CAUSE OF DEATH* was as follows:
Enteritis
..... (Duration) ..... yrs. 2 mos. ..... ds.
Contributory (Secondary) Acute Appendicitis following hemorrhage
..... (Duration) ..... yrs. 2 mos. ..... ds.
(Signed) Dr A M Newton M. D.
Aug 12 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Alliance Neb
DATE OF ~~BURIAL~~ shipment: Aug 1914

20. UNDERTAKER: Wallace & Wann
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 5-[illegible]
Registered No. 211

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Gen. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillie A Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. near as known Apr 12 (Month) (Day) 1872 (Year)

7. AGE: 41 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Stephen P. Moe

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Mercian Mack

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John W B Rogers
(Address) Inkom Idaho

15. Filed Aug 14 1914 O P Lucas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7th 1914, to Aug 13 1914, that I last saw her alive on Aug 13 1914, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Septic Infection at base of skull.

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary) Chronic Appendicitis (Duration several yrs. mos. ds.)

(Signed) F M Sprague M. D.
8-14 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 9 days. In the State Pocatello Gen. Hosp. ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? [redacted]
Former or usual residence Cerro Idaho

19. PLACE OF BURIAL OR REMOVAL: Fort Hall Cem — DATE OF BURIAL: Aug 15 1914

20. UNDERTAKER: Crawford & Schumacher — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SUPS. 24658

FORM V. S. No. 5-25 M. 1-16-13 Poole

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 3-[illegible]
Registered No. 212

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Ben Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Schwartz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Aug 13 (Month) 13 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Samuel Schwartz

11. BIRTHPLACE OF FATHER (State or Country) Austria Hungary

12. MAIDEN NAME OF MOTHER Minnie Goldberg

13. BIRTHPLACE OF MOTHER (State or Country) Romania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel Schwartz
(Address) 1415 N. Garfield

15. Filed Aug 14 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13 1914, to Aug 13 1914, that I last saw him alive on Aug 13 1914 and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Hemorrhage of mouth

(Duration) ..... Yrs. ..... mos. 1/2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. N. Poole M. D.
Aug 1914 (Address) Pocatello.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Aug 15 1914

20. UNDERTAKER: Crawford & Schumacher — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 14
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 506, N. Main St.)
File No. [illegible]
Registered No. 213

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecil Davis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 14 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Owen Davis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Hattie Barnett

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Owen Davis
(Address) Pocatello Idaho

15. Filed Aug 14 1914 O B Tuck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1914, to Aug 14 1914 that I last saw him alive on Aug 14 2:30 PM 1914, and that death occurred on the date stated above, at 6:00 M.

The CAUSE OF DEATH* was as follows:
Asphyxiation due to enlarged thymus gland

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. C. M. Newton M. D.
Aug 15 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Aug 16 1914

20. UNDERTAKER: Wallace & Mann — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6.20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 44
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 18, N. Harrison St.) File No. 5 [illegible]
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Mary E. O'[redacted] Registered No. 214
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed
6. DATE OF BIRTH: March 31 (Month) (Day) 1861 (Year)
7. AGE: 53 yrs. 4 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Pa.
10. NAME OF FATHER: Jas. M. Moomhammer
11. BIRTHPLACE OF FATHER (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Matilda Keeney
13. BIRTHPLACE OF MOTHER (State or Country): Pa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James K. Applewhite
(Address) Pocatello Idaho.
15. Filed Aug 20 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

DEATH occurred Aug (Month) 19 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from August 18 1914, to Aug 19 1914
that I last saw her alive on Aug. 18 1914
and that death occurred on the date stated above, at 2.30 A M.
The CAUSE OF DEATH* was as follows:
Brain embolism. This case not treated by a physician but by Christian Scientists.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
19 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah
DATE OF BURIAL ..... 191...
20. UNDERTAKER: Wadsworth & Sons
ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3[illegible]

Registered No. 215

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. 440 N. Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret F. Lesbe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 15th 1885 (Month) (Day) (Year)

7. AGE: 28 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Peter McCann

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Lucile Carling

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucile McCann

(Address) 440 N Hayes

15. Filed Aug 21 1914

J. J. Keeley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 21 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18th 1914, to Aug. 21st 1914, that I last saw her alive on Aug. 18th 1914, and that death occured on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) Several Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) W. A. Wright M. D.

8/16 1914 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Aug. 25 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3-

Registered No. 216

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1H
Primary Registration District No. 216
(No. 345, South 9th Ave St.)

2. FULL NAME Elenora Allen Reed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
Feb (Month) 17 (Day) 1848 (Year)

7. AGE
66 yrs. 6 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work None. Lived with son.
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Cary Thurman

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Rachel Simpkins

13. BIRTHPLACE OF MOTHER (State or Country) Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Reed
(Address) Pocatello Ida

15.
Filed Aug 24 1914
O B Steely
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at 3. A. M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis.
Treated by Christian Science

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. A. Roberts M. D.
8/23 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Magnon Ill
DATE OF ~~BURIAL~~ Shipment: Aug. 25 1914

20. UNDERTAKER: Wallace & Wann.
ADDRESS: Pocatello Id

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 1412 N First ave St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161

File No. 5
Registered No. 217
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Kepner

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 27 (Day) 1914 (Year)

7. AGE: yrs. 1 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello. Ida.

10. NAME OF FATHER: Ulysses Grant Kepner

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: ~~Hettie M. Brandt~~ Clara Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James A Poole
(Address) Pocatello. Ida

15. U G Kepner
Filed Aug 24 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Did not attend child at all
Father states that child died at 2 A.M. Aug 24th. I viewed the body at 6 P.M.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Marasmus
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James A Poole M. D.
Aug 24 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View	Aug 26 1914
20. UNDERTAKER	ADDRESS
Crawford & Schumacher	Pocatello

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. ____, Pocatello Ave. St.)
File No. 5
Registered No. 218

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank B. Woolke

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH ____ (Month) 1 (Day) ____ (Year)

7. AGE ____ yrs. ____ mos. ____ ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ____
(Address) ____

15. Filed Aug 30, 1914 O B Seeley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Probably Aug 28 — 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Found dead in bed, room 191 to ____ 191, that I last saw h____ alive on ____ 191, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Cardiac Asthma

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) O B Seeley, Coroner M. D.
Aug 30 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was Disease contracted, if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: Wallace & Vann — ADDRESS: Pocatello

Made to obtain information

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 84
Primary Registration District No. 2161
File No. 1-8780
County of Bannock
City of Pocatello (No. 512, S. 9th ave)
Registered No. 219
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME John William Starr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH: March (Month) 28 (Day) 1840 (Year)

7. AGE: 74 yrs. 5 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) R.R. Clerical Work

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maude E Dayton
(Address) Pocatello Idaho

15. Filed Sept 1st 1914 O B Seely Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1913, to Aug 31 1914, that I last saw h[illegible] alive on Aug 30 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Acute dilitation of Heart
(Duration) yrs. 3 mos. ds.
Contributory Mitral disease
(Secondary)
(Duration) 20 yrs. mos. ds.

(Signed) Francis N Poole M. D.
Sept 1 1914 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: Sept 2 1914

20. UNDERTAKER: Walker & Dann. — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

1914
10

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Boundary

Primary Registration District No. 3156

File No. 1

City of Bonners Ferry (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John George Roesch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: January (Month) 10th (Day) 1904 (Year)

7. AGE: 10 yrs. 6 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER John Roesch

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Mary Olden

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Roesch Sr
(Address) Post Falls Idaho

15.
Filed Aug. 8th. 1914 E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 7 (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Accidental drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.

8/8 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Post Falls Ida | DATE OF BURIAL: 8/9 1914

20. UNDERTAKER: J. J. Moore | ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Boundary

Primary Registration District No. 2156

City of Bonners Ferry (No. ..., ... St.)

File No. ...

Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John F. Farrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH ... (Month) ... (Day) 1 (Year)

7. AGE 57 yrs. ... mos. ... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Farrell

(Address) Bonners Ferry, Ida.

15.

Filed Aug. 9th 1914 E. E. Farrell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH August 9th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1913, to Aug. 8th, 1914 that I last saw him alive on Aug. 8th, 1914 and that death occurred on the date stated above, at 1.30 M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver.

(Duration) 2 yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) E. E. Farrell M. D.

8/9 1914 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days.

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	8/10 1914
20. UNDERTAKER	**ADDRESS**
John T. Moore	Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4

Registered No.

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 2157

County of Bonner

City of Bonners Ferry (If not in incorporated limits, give township.) No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Fred Benson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

October (Month) 1 (Day) 1881 (Year)

7. AGE

33 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumber Peler

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Peter Nelson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Lena Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olof Victor Benson

(Address) Bonners Ferry Ida

15.

Filed Aug. 12 - 1914 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July (Month) 8th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Drowning

(Suicidal)

(Body found Aug. 11th. 1914)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

19.... (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cabinet	8/12 1914

20. UNDERTAKER	ADDRESS
John J. Moore	Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 215-6

File No.

County of Bonner

City of Bonners Ferry (No. ....., ... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Viley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Single

6. DATE OF BIRTH: August 18 th 1914
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..2.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John R. Viley

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Nell B. Brown

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John R. Viley
(Address) Bonners Ferry, Ida.

15. Filed Aug. 18 th 1914 E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 18 th. 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mos.)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry, M. D.

8/18 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry, Ida	8/18/1914

20. UNDERTAKER	ADDRESS
John Moore	Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDPS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 2186

File No. [illegible]

County of Boundary

City of Bonners Ferry (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Viley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: August 18th 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. — ..... mos. — ..... ds.

IF LESS than 1 day how many ..1.... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John R. Viley

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Nell B. Brown

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R. Viley

(Address) Bonners Ferry, Ida

15. Filed Aug. 18th 1914 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August — 18th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 10½ A.M.
The CAUSE OF DEATH* was as follows:

Prematurity (6 mos.)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

8/18/1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry, Ida	8/18 1914
20. UNDERTAKER	ADDRESS
John Moore	Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8787

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Bear Lake

City of Liberty (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth McMurray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 21 (Day) 1838 (Year)

7. AGE: 75 yrs. 8 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brenston England

10. NAME OF FATHER: John Stenenson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Vickers

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Morgan
(Address): Liberty

15. Filed 9/24/ 1914 R. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...
that I last saw h... alive on ....., 191...
and that death occurred on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:
Brought to be heart Trouble
Died before a doctor could reach her.

(Duration) ..... yrs. ..... mos. .....

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. .....

(Signed) R. J. Sutton M. D.

19.... (Address) Paris Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Liberty, Ida. DATE OF BURIAL: Sept. 4, 1914

20. UNDERTAKER: Bishop Morgan ADDRESS: Liberty Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 513

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of Paris

(No. ..... St.)

Registration District No. 553

Primary Registration District No. 2692

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucile Shepherd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Single (Write the word.)

6. DATE OF BIRTH. December 4th 1908
(Month) (Day) (Year)

7. AGE ..5.. Yrs. ..9.. Mos. ..18.. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bear Lake Co Idaho

10. NAME OF FATHER Edwin Tracey Shepherd.

11. BIRTHPLACE OF FATHER (State or Country) Bear Lake Co Idaho

12. MAIDEN NAME OF MOTHER Elga Roberts

13. BIRTHPLACE OF MOTHER (State or Country) Bear Lake Co Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. L. Shepherd
(Address) Paris

15.
Filed 9/24/14 191.. P. Sutton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept 22 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 63, Sept 1914, to 22 Sept 1914, that I last saw her alive on Morning of Sept 22 1914, and that death occured on the date stated above, at 9:1 P M.

The CAUSE OF DEATH* was as follows:
Lack of Closure of Foramen Ovale

(Duration) Since birth Yrs. ..... mos. ..... ds.

Contributory (Secondary) Incompetence

10 Sept (Duration) 2 yrs. mos. 13 ds.

(Signed) P. Sutton M. D.

19.. (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Idaho — DATE OF BURIAL: Sept 24 1914

20. UNDERTAKER: O. L. Shepherd — ADDRESS: Paris Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ....., ... St.)

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Voorhees

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	(illegible)

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Lucien Voorhees

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Edyth Alej

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucien W Voorhees
(Address) Filer Ida

15. Filed 8-4 1914 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1914 to Aug 3 1914
that I last saw her alive on Aug 3 1914
and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D O Boyd M. D.
8/3 1914 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Aug 5 1914
20. UNDERTAKER	ADDRESS
J Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

County of Twin Falls

Primary Registration District No. 1085

City of " "

File No.

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jas. Frank Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Dec 16 1854 (Month) (Day) (Year)

7. AGE: 60 yrs. mos. ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Mathew S Smith

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Rachel C Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R P Smith
(Address) Rogerson Idaho

15.
Filed 8-3 1914 John Mortensen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914, to Aug 3 1914, that I last saw h alive on Aug 3 1914, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Fracture of skull

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J W Sayer M. D.
Aug 3 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days. In the State yrs mos days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: Aug 4 1914

20. UNDERTAKER: F J Grossman | ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 8791
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Henderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
8 (Month) 31 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Stewart Henderson

11. BIRTHPLACE OF FATHER (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Belle Willson

13. BIRTHPLACE OF MOTHER (State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stuart Henderson
(Address) .....

15.
Filed 8-31 1914 John K. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1914, to Aug 31 1914, that I last saw h— alive on Aug 30 1914, and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth,

(Duration) ..... yrs. Eleven hours. mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Wilson M. D.
Aug 31 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	Aug 31 1914
20. UNDERTAKER	ADDRESS
J. F. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 37
County of Twin Falls Primary Registration District No. 2085 File No.
City of " " (No. , St.) Registered No.
If death occurs away from usual residence, give facts called for under special information. If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen C Shank Dorman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widowed

6. DATE OF BIRTH: Feb. 27 (Month) (Day) 1849 (Year)

7. AGE: 65 yrs. 5 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeping
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Neil Tracy

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Martha Pucock.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J M Shank
(Address): Twin Falls Idaho

15. Filed Aug 10 1914 John Corgan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914 to Aug 8 1914, that I last saw her alive on Aug 8 1914 and that death occurred on the date stated above, at 1 19 M.

The CAUSE OF DEATH* was as follows:
Uremia

(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Chronic Bright's

(Duration) 2 yrs. mos. ds.
(Signed) John F Corgan M. D.
Aug 10 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: Aug 10 1914
20. UNDERTAKER: J J Sorensen | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of 11 11
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ____, ____ St.)

File No. 1403
Registered No. ____
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lula M. Lee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: June 27 (Month) (Day) 1886 (Year)

7. AGE: 28 yrs. 1 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Samuel Swolliger

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Louisa Spillman

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Lee
(Address) Filer

15.
Filed 8-12 1914 John D. Eagleson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914, to Aug 10 1914
that I last saw h.r. alive on Aug 10 1914,
and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:
Surgical Shock

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory (Secondary) Secondary Anemia
(Duration) 3 yrs. ____ mos. ____ ds.

(Signed) J. R. Morgan M. D.
Aug 12 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Ida. | DATE OF BURIAL: Aug 12 1914

20. UNDERTAKER: J. Grossman | ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 8791
Registered No. ____

1. PLACE OF DEATH.
County of Twin Falls.
City of 11 11 (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Dooley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
(Month) — (Day) 1 (Year) —

7. AGE
____ yrs. ____ mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry business, or dstablishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: E. R. Dooley

11. BIRTHPLACE OF FATHER (State or Country): Ga.

12. MAIDEN NAME OF MOTHER: Edith Siddle

13. BIRTHPLACE OF MOTHER (State or Country): N York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E R Dooley
(Address) Filer, Idaho.

15.
Filed 8-15 1914 John D Coughlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
aug. (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 15 1914, to aug 15 1914, that I last saw her alive on aug 15 1914 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H W Wilson M. D.
aug 17 1914 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Filer Ida. DATE OF BURIAL: aug 15 1914

20. UNDERTAKER: J. J. Sweeney ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 510
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Emanuel Errickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: Swedish white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
March 27 1887
(Month) (Day) (Year)

7. AGE
27 Yrs. 4 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER
A Errickson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER
Anna Lyung

13. BIRTHPLACE OF MOTHER
(State or Country) Swedeth

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arvid Erickson
(Address) Twin Falls

15.
Filed 8-17 1914
John F Eagle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 16th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/2/ 1914, to 8/16/ 1914, that I last saw h[illegible] alive on 8/16/ 1914, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Typhoid fever
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) W. F. Pike M. D.
8/17 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 8/18 1914

20. UNDERTAKER: L Marsh — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 206
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James David Neighbors

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 29 (Day) 1912 (Year)

7. AGE: ..... Yrs. 22 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: C. A. Neighbors

11. BIRTHPLACE OF FATHER (State or Country): McPherson Kas

12. MAIDEN NAME OF MOTHER: May Beatty

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): C. A. Neighbors.
(Address): Empedria Kansas

15.
Filed Aug. 18 1914
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 17th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1914, to Dec 17 1914, that I last saw him alive on Dec 17 1914, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Worden M. D.
Aug 18 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 8/18 1914

20. UNDERTAKER: L. Marsh — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37

Primary Registration District No. 1085

File No. 870

Registered No.

1. PLACE OF DEATH.

County of Twin Falls

City of .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Gerken

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	(Write the word) Married

6. DATE OF BIRTH: May (Month) 21 (Day) 1895 (Year)

7. AGE: 19 yrs. 3 mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Hand.
(b) General nature of industry, business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Gerken

(Address) Twin Falls

15. Filed Aug. 27 1914 John Engleken Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914, to Aug 26 1914, that I last saw h[illegible] alive on Aug 26 1914, and that death occurred on the date stated above, at 3 a.m. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Wilson M. D.

Aug 28 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Aug 28 1914
20. UNDERTAKER	ADDRESS
J. P. Grossman	Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 31

County of Twin Falls Primary Registration District No. 1086

City of " " (No. ....., ... St.)

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruben J Hobson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 31 (Day) 1851 (Year)

7. AGE: 63 yrs. 4 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Thomas Hobson

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Anna Tally

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ruben J Hobson
(Address) Twin Falls Idaho

15. Filed 8.26 1914 John Douglass Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1914, to Aug 24 1914, that I last saw him alive on Aug 22 1914, and that death occurred on the date stated above, at 9P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) several yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Charles E. Scott M. D.

Aug 26 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 2 mos. ..... days. In the State ..... yrs. 4 mos. ..... days.

Where was disease contracted if not at place of death? La Louisiana

Former or usual residence Louisiana

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: Aug 26 1914

20. UNDERTAKER: C. J. Freeman | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1174

Registered No. 3

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Eliza Fish

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 12 (Month) (Day) 1878 (Year)

7. AGE: 36 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... milliner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angus Sutherland

(Address) Wallace Idaho

15.

Filed Aug 29 1914 H. Leo Dunphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1914, to Aug 28 1914, that I last saw h[illegible] alive on Aug 28 1914, and that death occured on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) none

(Duration) yrs. mos. ds.

(Signed) Ora Woodward M. D.

(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Michigan

Former or usual residence Wallace, Idaho

19. PLACE OF BURIAL OR REMOVAL: Nashville Mich — DATE OF BURIAL: Aug 30 1914

20. UNDERTAKER: Bruce G. Woodell — ADDRESS: Wallace, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 6-15-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 7
Primary Registration District No. 1011
File No. 8806
County of Shoshone
City of Wallace (No. Providence Hospital St.)
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Lefavor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. April (Month) 27 (Day) 1889 (Year)

7. AGE 25 Yrs. 3 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Minn.

10. NAME OF FATHER Wm Lefavor

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Yontsey

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S K Sonnett
(Address) Wallace, Idaho
8/23 1914 C F L [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1914, to Aug 22 1914, that I last saw h[illegible] alive on Aug 22 1914, and that death occured on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Gangrenous Appendicitis
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) D E Moderwell M. D.
8/23 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 0 yrs. 6 mos. 14 days In the State 25 yrs. 0 mos. 0 days
Where was disease contracted if not at place of death? Burke Idaho
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
Aug 24 1914
Undertaker
Address Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. ..., ... St.)

Registration District No. 570
Primary Registration District No. 1011
File No. ...
Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Bunnich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ... (Month) ... (Day) 1891 (Year)

7. AGE: 23 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Peter Dunnich

11. BIRTHPLACE OF FATHER (State or Country): Austria Brunsayoi Gmunyoi

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Brunsayoi Gmunyoi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel R. Koch
(Address) Silver King Mine Co.

15. Filed Aug 15 1914 J. F. Leonard Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1914, to Aug 14 1914, that I last saw him alive on Aug 13 1914 and that death occured on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... Yrs. ... mos. 1½ ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) D. K. Mowery M. D.

Aug 17 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Aug. 16 1914

20. UNDERTAKER: Wards Undertaking Co. — ADDRESS: Wallace

2da

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. [illegible]
Registered No. 54

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Hope Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dennis Hennessy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
(Month) (Day) 1849 (Year)

7. AGE
65 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Patrick

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Whelan
(Address) Wallace Ida

15.
Filed Aug 14 1914
F L Swingley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1914, to Aug 13 1914, that I last saw him alive on Aug 13 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chr Parenchymatous Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Max T. Semple M. D.
8-14 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Aug 15 1914
20. UNDERTAKER: Bruce & Wooster — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Burke
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 101
(No. ....., ... St.)

File No. 8805
Registered No. 57
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rufus Benjamin Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Nov. (Month) 12 (Day) 1864 (Year)

7. AGE
49 yrs. 8 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Lead Miner
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER Wm Davis

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Josie Davis
(Address) Webb City Mo

15.
Filed Aug 10 1914 J. Leo Linville Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1914, to Aug 10 1914, that I last saw h..... alive on Aug 4 1914, and that death occurred on the date stated above, at 6. A M.

The CAUSE OF DEATH* was as follows:
Pneumonia no

..... (Duration) ..... yrs. 5 mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A Bruce M. D.
Aug 1910 (Address) Burke, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE ~~OF BURIAL OR~~ REMOVAL: Webb City Mo
DATE OF BURIAL: Aug 10 1914

20. UNDERTAKER: Ward U. Leo
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

23

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 32

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 10 11

(No. Providence Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Galiazzi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 47 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Dawbel, Austria

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Ragozzelli

(Address) Wallace Ida

15. Filed Aug 1 1914

F Leo Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1914, to July 30 1914, that I last saw h alive on July 30 1914 and that death occured on the date stated above, at 8 00 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) D. D. Mowery M. D.

1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Aug 2 1914

20. UNDERTAKER: F G Worstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. 675 - 16th S St.)
File No.
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin E. Utley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 3 (Month) 22 (Day) 1829 (Year)

7. AGE: 85 yrs. 4 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Co. N.Y.

10. NAME OF FATHER: Erastus Jerome Utley

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE ~~TO THE BEST OF MY KNOWLEDGE~~
(Informant) Mrs Driscoll
(Address) Payette, Idaho

15.
Filed Aug 7 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 6 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1914, to Aug 6 1914,
that I last saw him alive on Aug 6 1914,
and that death occurred on the date stated above, at 3.30 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Woodward M. D.
Aug 8 1914 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nussen Idaho | DATE OF BURIAL: Aug 8 1914

20. UNDERTAKER: J. H. Adair | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 880
Registered No. 16

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Curliss Chapman
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan (Month) 12 (Day) 1893 (Year)

7. AGE: 21 yrs. 6 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Samuel Chapman

11. BIRTHPLACE OF FATHER (State or Country): Kis

12. MAIDEN NAME OF MOTHER: Sadie K Palmer

13. BIRTHPLACE OF MOTHER (State or Country): Kis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O E Chapman
(Address) Payette Ida

15. Filed Aug 8 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 8 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1914, to Aug 8 1914, that I last saw him alive on Aug 8 1914, and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:
Gangrenous Appendicitis

(Duration) ... yrs. ... mos. 13 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J C Woodward M. D.
Aug 8 1914 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL | DATE OF BURIAL
Payette Ida | Aug 8 1914

20. UNDERTAKER: J. H. Adair | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 4

County of Canyon Primary Registration District No. 1008

City of Payette, (No. ..., ...St.)

File No. [illegible]

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph R Anderson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1884 (Year)

7. AGE: 30 yrs. 7 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: J R Anderson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary A Brown

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J R Anderson

(Address) Payette Ida

15. Filed Aug 14 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1914, to Aug 13 1914, that I last saw h[illegible] alive on Aug 13 1914, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Electrocution by contact with uninsulated wire, carrying 440 Volts

(Duration) About 3 minutes

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J C Woodward M. D.

Aug 14 1914 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence: Removed

19. PLACE OF BURIAL OR REMOVAL: Taylorville Ill. DATE OF BURIAL: Aug 15 1914

20. UNDERTAKER: E N Adair Payette ADDRESS: Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ..., ... St.)

File No. [illegible]
Registered No. 18
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena Fraser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
April (Month) 3 (Day) 1888 (Year)

7. AGE
26 yrs. 5 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Fraser

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Theresa Moser

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Fraser
(Address) Payette Idaho

15.
Filed Aug 31 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug. (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1912, to Aug. 30 1914, that I last saw her alive on Aug 30 1914, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) About 5 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O. H. Avey M. D.
19 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Billion His | DATE OF BURIAL: Aug 31 1914

20. UNDERTAKER: D. D. Adair | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Lucile

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Southard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: (Month) (Day) 1876 (Year)

7. AGE: 38 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Keegan

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Southard
(Address) Lucile Ida

15.
Filed ..... 191...
W A Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 21 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1914, to Aug 21 1914 that I last saw her alive on June 10 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Anemia from Hemorrhage at child birth with some unknown complication
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W A Foskett M. D.
19 (Address) Whitebird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: John Day
DATE OF BURIAL: Aug 23 1914

20. UNDERTAKER: no undertaker
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2250
(No. Burke Idaho St.)

File No. [illegible]
Registered No. 20

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Charles Byers

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 33 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Charles Byers

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Breyer

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Rose Byers
(Address) Burke Ida

15. Filed Aug 31 1914 H. C. Mowry Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 191..., to ——, 191..., that I last saw him alive on Aug 26 1914 and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows: Accidental fall in shaft of Hecla mine causing numerous fractures skull & other parts of body

(Duration) Yr. mos. ds.

Contributory (Secondary)

Duration yrs. mos. ds.

(Signed) Chas. R. Mowry M. D.
(Address) Wallace Ida Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idah. DATE OF BURIAL: Aug 31st 1914

20. UNDERTAKER: B. G. Worstell ADDRESS: Wallace Ida

FORM V. S. No. 5-25 — 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 811

Registered No. 19

1. PLACE OF DEATH.

Registration District No. 127

Primary Registration District No. 2200

County of Shoshone

City of St Maries (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M'Donald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Don't know

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 ..... (Year)

7. AGE Between 45 & 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Worked in

(b) General nature of industry, business, or establishment in which employed (or employer)..... Lumber camp

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) St Maries Ida

15. Filed Aug 20 1914

H. S. Mowry
Local Registrar

SYMS - YORK CO., PTGS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found dead @ 6 o'Clock A. M.
Aug 16 1914
Alcoholism

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas E. Mowry M. D.

8/18 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL St Maries Ida — DATE OF BURIAL ..... 191...

20. UNDERTAKER R. L. Finkesley — ADDRESS St Maries, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Mullan

Registration District No. 122
Primary Registration District No. 2005
(No. ....., ... St.)

File No. .....
Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis S. Claflin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1854 (Year)

7. AGE: 60 yrs. 5 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rochester N.Y.

10. NAME OF FATHER: L Claflin

11. BIRTHPLACE OF FATHER (State or Country): Rochester N.Y.

12. MAIDEN NAME OF MOTHER: Laura Lambkins

13. BIRTHPLACE OF MOTHER (State or Country): Rochester N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Claflin
(Address) Mullan Ida

15. Filed Sept 15 1914 F.C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1914, to June 4 1914, that I last saw her alive on June 4 1914 and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia,

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Ptomain poisoning

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F W Wolfe M. D.

June 4 1914 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Mountain View Cemetery Mullan Ida — DATE OF BURIAL: June 6 1914

20. UNDERTAKER: Warde Undertaking Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12a

County of ..... Primary Registration District No. 2200

City of ..... (No. ....., ... St.)

File No. .....

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis A Saari

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 7 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mullan Idaho

10. NAME OF FATHER: Frank Saari

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Paulo

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James R Bean
(Address) .....

15. Filed Sept 15 1914 H. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1914, to May 15 1914, that I last saw h[im] alive on May 14 1914 and that death occurred on the date stated above, at 1[st] a M.

The CAUSE OF DEATH* was as follows:

Mal Nutrition

..... (Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.

May 15 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida — DATE OF BURIAL: May 16 1914

20. UNDERTAKER: Ward Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
(No. ....., ... St.)

Registration District No. 12
Primary Registration District No. 2200

File No. .....
Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Richard Wheatley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 17 (Day) 1855 (Year)

7. AGE: 59 yrs. 1 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): County Wicklow Ireland

10. NAME OF FATHER: John Wheatley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Sarah Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Wheatley
(Address) Mullan Idaho

15. Filed: Sept 15 1914 H. E. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to May 14 1914
that I last saw him alive on May 14 1914
and that death occurred on the date stated above, at 7:45 P.M.
The CAUSE OF DEATH* was as follows:

Uraemia
6 weeks
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Nephritis (Interstitial)
(Duration) 2 yrs. — mos. — ds.

(Signed) James R Bean M. D.
May 15 1914 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn Cem Mullan DATE OF BURIAL 1914

20. UNDERTAKER: ..... ADDRESS Wallace Idaho

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 17148

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Mc Cammon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2047
(No. ....., ... St.)

File No. 8815
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. L. Steel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	W.	

6. DATE OF BIRTH: Jan. (Month) 31 (Day) 1901 (Year)

7. AGE: 13 yrs. 5 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Ida.

10. NAME OF FATHER: John H. Steel

11. BIRTHPLACE OF FATHER (State or Country): Farmington, Utah.

12. MAIDEN NAME OF MOTHER: Mary Chandler

13. BIRTHPLACE OF MOTHER (State or Country): Willard Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Steel
(Address) Parkman, Idaho

15.
Filed Sep 10, 1914 Lee Kenner
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug - 1st 1914, to Aug - 14 1914, that I last saw h~~im~~ alive on Aug 14th 1914 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Appendicitis

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) G. H. Cooper M. D.

19..... (Address) Mc Cammon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Removal Parkman	Aug 16, 1914

20. UNDERTAKER: Roy Fiscus — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

File No.

County of Bannock

City of Bancroft (No. , St.)

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leo Cassoni Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
m	w	Single

6. DATE OF BIRTH: July (Month) 8 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leo Cassoni

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Dusa Phillipsa

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dan Cassoni
(Address) Bancroft, Ida

15.
Filed Sept 10, 1914 Eric Kary
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1914, to July 8 1914, that I last saw h in alive on July 8 1914 and that death occurred on the date stated above, at 8 p M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R Rupert M. D.

July 7 1914 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bancroft — DATE OF BURIAL: July 9 1914

20. UNDERTAKER: Nuns — ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2210

Registered No. 201

1. PLACE OF DEATH.

County of Boise

City of Placerville

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Elmer Iddings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 31 (Month) (Day) 1883 (Year)

7. AGE: 30 Yrs. 9 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Wholesale
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber dealer

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER I. G. Iddings

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Maud Queen
(Address) Boise Ida.

15.
Filed 8-26 1914 J. W. Porter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1914, to Aug 23 1914, that I last saw h[illegible] alive on Aug 23 1914, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Rupture of Internal Viscera from accident

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Shock & Exposure

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. S. Tuttle M. D.

8 24 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salem Ore. DATE OF BURIAL: Aug 26 1914

20. UNDERTAKER: Terry & Summers ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. .....
Registered No. 38

1. PLACE OF DEATH.
County of Elmore
City of P.O. Smiths Prairie
(No. near Smiths Prairie St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Aaron Donnelly.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 15 (Day) 1852 (Year)

7. AGE: 64 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Peru.

10. NAME OF FATHER: San Donnelly

11. BIRTHPLACE OF FATHER (State or Country): Peru.

12. MAIDEN NAME OF MOTHER: Julia Ann Gray

13. BIRTHPLACE OF MOTHER (State or Country): Peru.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Wm Bedal
(Address) Highland Ida

15. Filed 8-30 1914 W.S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 28th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased ~~from~~
Died ~~191—~~ to Aug 28 1914,
that I last saw h alive on Aug 28 1914,
and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
No Physician in attendance
took ill Friday Aug 14-1914
Drinks cause of death Blood
~~Poison~~ (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Mrs Wm Bedal M. D.
19 ..... (Address) Dangerous Highland Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Smiths Prairie Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 30 1914

20. UNDERTAKER: Schreiber & Hedenskoven — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654.

no Doctor

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1005

(No. St. Alphonsus Hospital)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 184

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada.

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cicile L. Weddle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. June (Month) 21 (Day) 1890 (Year)

7. AGE 24 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER John R Weddle

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Alice G. Ennis

13. BIRTHPLACE OF MOTHER (State or Country) Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. J. Weddle

(Address) Boise Ida.

15.

Filed Aug 1 1914 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1914, to July 31 1914, that I last saw h[illegible] alive on July 31 1914, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Thrombosis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Compound fracture of skull

(Duration) ..... yrs. ..... mos. 53 ds.

(Signed) W S Peters M. D.

7-31 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Joppenish Wash. **DATE OF BURIAL** Aug 2 1914

20. UNDERTAKER Hoyt Sumners **ADDRESS** Boise Ida

SYMS - YORK CO., PTRS. & SORS. 24653

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 1804
File No.
Registered No. 187

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1206 Lemp Ave St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carthur Norman Randall

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 25 (Day) 1914 (Year)

7. AGE: ——— Yrs. 3 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ———
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: Edward Randall

11. BIRTHPLACE OF FATHER (State or Country): London England

12. MAIDEN NAME OF MOTHER: Gena K Lootundt

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Arthur Randall
(Address) 1206 Lemp St Boise

15. Filed 8—5 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1914, to Aug 2 1914, that I last saw h sm alive on Aug 3 1914, and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:
entero colitis

(Duration) Yrs. 3 mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) M D Ballenger M. D.
8/4 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: Aug 5 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

BYRNS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8822
Registered No. 188

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 460 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Lourette Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
September 20 1886
(Month) (Day) (Year)

7. AGE
27 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Calhoun Co Michigan

10. NAME OF FATHER: Clinton D Cannon

11. BIRTHPLACE OF FATHER
(State or Country) United States

12. MAIDEN NAME OF MOTHER: Dell Nye

13. BIRTHPLACE OF MOTHER
(State or Country) United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur W Hansen
(Address) Shoshone Idaho

15.
Filed 8-7 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 7th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5th 1914, to Aug 6 1914, that I last saw h[illegible] alive on Aug 6th 1914, and that death occured on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:
Puerperal Septicaemia (Childbed fever)

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) L. P. McCalla M. D.
19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho
DATE OF BURIAL: .....191.....

20. UNDERTAKER: Schreiber & Siebenfaden
ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 8809
Registered No. 189

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 415 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geraldine Eliza Kennedy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Aug (Day) 7 (Year) 1914

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: Frank C. Kennedy

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Eddie C. Marshall

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. C. Kennedy
(Address) Idaho City

15. Filed 8-7 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) Aug (Day) 7th 191 7 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 10A. M.

The CAUSE OF DEATH* was as follows:
Premature Birth
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration ..... Yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
8/8 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho City, Ida. DATE OF BURIAL: 8/8 1914

20. UNDERTAKER: Schreiber & Siddenfaden Funeral ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004.
File No. ____
Registered No. 190

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 305 S 4th St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laurence James Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Oct. (Month) 7 (Day) 1913 (Year)
7. AGE: 1 Yrs. 10 Mos. 1 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): ____
9. BIRTHPLACE (State or Country): Boise
10. NAME OF FATHER: Christofer John Thomas
11. BIRTHPLACE OF FATHER (State or Country): Mich.
12. MAIDEN NAME OF MOTHER: Dora Bell Sinsinger
13. BIRTHPLACE OF MOTHER (State or Country): Mont.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chris Thomas
(Address) 305 S 4th
15. Filed 8-10 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 9 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1914, to Aug 8 1914, that I last saw h[illegible] alive on Aug 8 1914 and that death occured on the date stated above at 9:30A M.
The CAUSE OF DEATH* was as follows:
Gastro-enteritis
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) ____
(Duration ____ yrs. ____ mos. ____ ds.
(Signed) [signature] M. D.
8/10 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs ____ mos ____ days In the State ____ yrs ____ mos ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 10 1914
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Returns.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. .....

Registered No. 191

1. PLACE OF DEATH.

County of Ada

City of Boise.

(No. 529 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie Van Hook

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 15th (Day) 1851 (Year)

7. AGE: 62 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Akron. Ohio

10. NAME OF FATHER: Jacob Thompson

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Jane Hall

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Wanford Ki...

(Address) 529 E. Bannock St. Boise

15. Filed 8-13 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 12th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Aug 12 1914, that I last saw her alive on March 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis & mitral regurgitation

Valvular disease heart

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Mrs B Lyman M. D.

19.... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/14 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 826
Registered No. 192

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410 Fleta St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harvey Lyman Richardson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. December 13 (Month) (Day) 1878 (Year)
7. AGE: 35 Yrs. 8 Mos. ds. IF LESS than 1 day how many ...hrs. or ...min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Office work
(b) General nature of industry, business, or establishment in which employed (or employer)... Physician
9. BIRTHPLACE (State or Country) Boise Ada Co. Idaho
10. NAME OF FATHER A. L. Richardson
11. BIRTHPLACE OF FATHER (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Carolina A. Smith
13. BIRTHPLACE OF MOTHER (State or Country) Hillsborough Co.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. L. Richardson
(Address) Boise. Idaho
15. Filed 8-14 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 12 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1914, to Aug 12 1914, that I last saw h[illegible] alive on Aug 12 1914, and that death occured on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:
Hemorrhage from
Ulcer of Stomach
(Duration) ...Yrs. ...mos. ...ds.
Contributory (Secondary)
(Duration) ...Yrs. ...mos. ...ds.
(Signed) M. S. Parker M. D.
8/13 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Aug. 16 1914
20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMB - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 rev. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8827

Registered No. 178

1. PLACE OF DEATH.

County of Ada.

City of Boise.

Registration District No.....

Primary Registration District No. 1

(No. 2007 No 9 St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Gable.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.): Single

6. DATE OF BIRTH. Aug (Month) 1 (Day) 1841 (Year)

7. AGE: 73 Yrs. — Mos. 13 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Physician
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER John Gable.

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Susannah Stamp.

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L E Bunch
(Address) Boise Idaho

15. Filed 8-19 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Aug 14 1914, that I last saw h[illegible] alive on Aug 14 1914 and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis

(Duration) 15 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) M. N. Dallman M. D.

8/15 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Osage Down. DATE OF BURIAL: Aug 19 1914

20. UNDERTAKER: Fry & Summers. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 892
Registered No. 192

1. PLACE OF DEATH.
County of Ada.
City of Boise.
(No. 419 So 4 St. St.)
Registration District No.
Primary Registration District No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant M. McDonald.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH.
Aug (Month) 13 (Day) 1914 (Year)

7. AGE
— Yrs. — Mos. — ds.
IF LESS than 1 day how many... 1½ hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: H. C. McDonald.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lura G. Jayne.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H C McDonald
(Address) 419 So 4th Boise Idaho

15.
Filed Aug 15 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13-14 1914, to Aug 13-14 1914, that I last saw h[illegible] alive on Aug 13-14 1914, and that death occured on the date stated above, at 2.45 A.M.

The CAUSE OF DEATH* was as follows:
Premature birth (estimated Gestation period 227 days)

(Duration) 0 Yrs. 0 mos. 0 ds.
Contributory (Secondary) Inhaled blood & mucus during birth.
Duration yrs. mos. ds.

(Signed) J. M. Taylor M. D.
Aug 15 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Aug 15 1914

20. UNDERTAKER: Fry & Summers Co. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOLS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 195 892
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 32 W Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Cone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 15 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: John Cone

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Sallie Dayton

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Cone
(Address) .....

15. Filed Aug 16 1914 W. B. Dyer Local Registrar

SYMS - YORK CORP'N PTRS. & SOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1914, to Aug 15 1914, that I last saw him alive on Aug 15 1914, and that death occured on the date stated above, at 12 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth
Loss vitality
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) M. Allen Callaway M. D.
19 ..... (Address) 820½ Idaho Street

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/16 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8409

Registered No. 196

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.....

Primary Registration District No.....

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lottie E Hunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6. DATE OF BIRTH. Mar (Month) 2 (Day) 1849 (Year)

7. AGE 65 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Rockport Mo

10. NAME OF FATHER Richard Buckam

11. BIRTHPLACE OF FATHER (State or Country) Ky

12. MAIDEN NAME OF MOTHER Nancy White

13. BIRTHPLACE OF MOTHER (State or Country) Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. C. Hutchinson

(Address) Phoenix, Ariz.

15.

Filed S 20 1914 [illegible] Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1914, to Aug 19 1914, that I last saw h.er alive on Aug 19 1914, and that death occured on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of heart

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) Shock of Ether anesthesia

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) L. D. McCall M. D.

8/21 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 5 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Rockport Mo.

19. PLACE OF BURIAL OR REMOVAL Rockport Mo. DATE OF BURIAL 8/20 1914

20. UNDERTAKER Schreiber & Siebenfaden ADDRESS Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 533

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 419 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Bolline

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. not obtainable (Month) (Day) 1861 (Year)

7. AGE about 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Italy.

10. NAME OF FATHER V. Bolline

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mike Bellisio

(Address) .....

15.

Filed ..... 191.....

Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 19 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1914, to Aug 19 1914, that I last saw h.i.m. alive on Aug 18 1914, and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic nephritis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Ball M. D.

8/25 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 8/21 1914

20. UNDERTAKER: Eckenberg & Siebenfaden — ADDRESS: Boise, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. .....
Registered No. 200

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 1113 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Eastman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug 21st 1914 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Fred. Eastman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Idat Norris

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Fred Eastman
(Address): Nampa, Idaho

15. Filed 8-22 1914 M. L. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 22nd 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1914, to Aug 21 1914, that I last saw him alive on Aug 21 1914, and that death occured on the date stated above, at 2A M.

The CAUSE OF DEATH* was as follows:
Premature birth
and Lack vitality

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M Allen Calloway M. D.
1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence: Nampa Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 8/22 1914

20. UNDERTAKER: Pierce & Sidengaden | ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. St. Alphonsus Hospital)

File No. 8833
Registered No. 207

1. PLACE OF DEATH.
County of Ada.
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant McQuery.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. ~~(Write the word.)~~

6. DATE OF BIRTH. Aug 19 (Month) (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Arlie McQuery.

11. BIRTHPLACE OF FATHER (State or Country) Arkansas.

12. MAIDEN NAME OF MOTHER Emma Schaub.

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arlie McQuery
(Address) Boise Ida.

15. Filed 8-25 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1914, to Aug 24 1914, that I last saw him alive on Aug 24 1914, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Spina Bifida. Meningitis.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.
8/26/1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Aug 25 1914

20. UNDERTAKER: Fry & Summers. ADDRESS: Boise Ida.

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 203

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration [redacted]

Primary Re[redacted]

(No. 110 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah J Aver

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. November (Month) 10th (Day) 1846 (Year)

7. AGE: 67 Yrs. ..... Mos. 9 ds. 14

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)... F

9. BIRTHPLACE (State or Country) East Tennesse

10. NAME OF FATHER Philip Henshaw

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Not ob[illegible] Sarah J Henshaw

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H B. Aver

(Address) East Lake Utah

15.

Filed [illegible] 191[illegible]

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug - 13 1914, to Aug 24 1914, that I last saw her alive on Aug 24 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Aug 25 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 26 1914

20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-15

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. .....
Registered No. .....

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 420 S. 4th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Willoughby Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 19th (Day) 1914 (Year)

7. AGE: 0 Yrs. 0 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: G. W. Hall

11. BIRTHPLACE OF FATHER (State or Country): So. Dak

12. MAIDEN NAME OF MOTHER: Helena E. Gregary

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George W. Hall
(Address) 420 So. 4th

15. Filed 8-26 191[illegible] W. S. Porter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/1 1914, to 7/5 1914, that I last saw him alive on 25 1914, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. 4 ds.

(Signed) M L Allen M. D.

19 (Address) 202-203 W Clark Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence 420 S. 4th Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Harris Hill Cemetery — DATE OF BURIAL: 8/26 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

Dr. Allen.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8836

Registered No.

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.....

Primary Registration District No.....

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Emmaline Carringer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 16 (Day) 1887 (Year)

7. AGE: 27 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): S. Dak.

10. NAME OF FATHER: Chas G. Goetling

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Emma Gateman

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Carringer

(Address) Eagle RR 1 Ada

15.

Filed 8-27 1914 Wm. Sanborn Local Registrar

Fellman

SYMS - YORK CO., PTRS. & SOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1914, to Aug 26 1914, that I last saw her alive on Aug 25 1914, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Metrorrhagia from following inflammatory rheumatism

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) M. H. Fellman M. D.

8/26 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 10 days In the State.....yrs.....mos. 4 days

Where was disease contracted if not at place of death?.....

Former or usual residence Eagle Idaho

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: 8/27 1914

20. UNDERTAKER: Schreiber & Siebenfeden — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 58

Registered No. 232

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.

Primary Registration District No.

(No. 29 and Alturas St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 24 (Day) 1912 (Year)

7. AGE: 2 Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: John H. Campbell

11. BIRTHPLACE OF FATHER (State or Country): U. S. Canada

12. MAIDEN NAME OF MOTHER: Myrtle E. Kingsley

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Campbell

(Address)

15. Filed 8-29 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 29th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1914, to Aug 29th 1914, that I last saw him alive on Aug 28th 1914, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Convulsions - caused from inspection of salivary glands parotid

(Duration) Yrs. mos. 57 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) [illegible] M. D.

Aug 29 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence 29 and Alturas Boise, Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/29 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Idaho

Dr. Boork

BYMS - YORK CO., PTRS. & BDRS. 24654

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.

File No. 8838
Registered No. 208

1. PLACE OF DEATH.

County of Ada
City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orrin James Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 4 1886 (Month) (Day) (Year)

7. AGE: 28 Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Harry G. Jackson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Griffeth

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry G Jackson
(Address) Maryfield Idaho

15. Filed 8-30 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 30 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 29 1914, to Aug 30 1914, that I last saw him alive on August 30 1914, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Acute Suppurative Appendicitis

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) [illegible] M. D.
Aug 31 1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) St Alphonsus Hospital
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Maryfield Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/31 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. [illegible]
Registered No. 32

1. PLACE OF DEATH.
County of Ada.
City of Boise
(No. Soldiers Home, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles St John.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Unknown 1
(Month) (Day) (Year)

7. AGE
76 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Civil War.
(b) General nature of industry, business, or establishment in which employed (or employer)... Veteran

9. BIRTHPLACE
(State or Country) Unknown

10. NAME OF FATHER
Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER
Unknown.

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. G. Burnet
(Address) Soldiers' Home

15.
Filed 8-2 1914
M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1914, to Aug 2 1914, that I last saw ~~he~~ alive on Aug 2 1914, and that death occured on the date stated above, at 9:30 PM

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) Fred. A. Young M. D.

1914 (Address) Jack Bell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: Aug 4 1914

20. UNDERTAKER: Amy & Summers ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 7004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8540

Registered No. 83

1. PLACE OF DEATH.

County of Ada

City of Near Boise

(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin F. Hogan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Not Obtainable (Month) 1 (Day) 843 (Year)

7. AGE: 71 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Veteran Civil War

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. F. Burnett.

(Address) Soldiers Home.

15. Filed 8/21 1914 M. S. Parker Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914 to Aug 20 1914 that I last saw him alive on Aug 19 1914 and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

General Paresis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) Fred A. Kellogg M. D.

8/20 1914 (Address) Lack Block

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Aug 21 1914

20. UNDERTAKER: Frye & Summers

ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2052

File No. 8841

Registered No. 34

1. PLACE OF DEATH.

County of Ada

~~City of~~ Snake River

(No. 6 Miles Below Swan Falls on Snake River)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pedro Igarzaca

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. not Obtainable 91
(Month) (Day) (Year)

7. AGE about 23 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Spain

10. NAME OF FATHER Pedro J. Igarzaca

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antonio Letamendi

(Address) Boise Idaho

15. Filed 8-21 1914

M. L. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 11th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased ~~from~~ ~~191~~ ~~to~~ ~~191~~ ~~that I last saw him alive on~~ died Aug. 20 ~~191~~ 1914 and that death occured on the date stated above, at 8-20 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning falling of the ferry Boat at Swan Falls Power Plant

according to statements of ~~Dr.~~ Contributory (Secondary) Fright and cold took a man afflicted with disease of the heart

Duration ~~yrs.~~ ~~mos.~~ ~~ds.~~

(Signed) Adolph Schreiber Coroner

19..... (Address) Boise Ida. Ada Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	Aug 21 1914
20. UNDERTAKER	**ADDRESS**
Schreiber & Anderson	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No.
Registered No. 37

1. PLACE OF DEATH.
County of Ada
~~City of~~ Eagle
(No. near Eagle St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mark Henry Harris
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Aug. (Day) 16 (Year) 1867

7. AGE: 47 Yrs. ... Mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: James M Harris

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Jennette Bilbrey

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John H Harris
(Address)

15. Filed 8 26 1914 — M S Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Aug (Day) 24 (Year) 1914

17. I HEREBY CERTIFY, That I attended deceased from June 23 1914, to Aug 24 1914, that I last saw h-im alive on Aug 16 1914, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
(Duration) 40 Yrs. 2 mos. ds.
Contributory (Secondary) Auricular fibrillation
(Duration 2 yrs. mos. ds.
(Signed) M. H. Dallman M. D.
8-25 1914 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Joplin Cemetery — DATE OF BURIAL: Aug 26 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ..... St.)
File No. .....
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka
City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence H Mastin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 6th (Day) 1877 (Year)

7. AGE 37 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work. Insurance agent

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Charles H Mastin

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER dont Know

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C H Mastin

(Address) .....

15.

Filed ..... 191....

C H Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1914, to Aug 2 1914,

that I last saw h[illegible] alive on Aug 1 1914,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Heart Trouble

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration) 20 yrs. ..... mos. ..... ds.

(Signed) C. F. Toomey M. D.

.....19..... (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rupert — **DATE OF BURIAL** aug 4 1914

20. UNDERTAKER W A Goodenough — **ADDRESS** Rupert.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24853

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

ath Certificate No. 8843

me Clarence H. Mastin

te of Death August 2nd, 1914

use of Death Heart Failure

ntributary Cause of death Acute Endocarditis

(Sign here) W. H. Hoover M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8844

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Minidoka

City of Rupert (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mable Powers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: [illegible]

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Mar (Month) 31 (Day) 1914 (Year)

7. AGE: 0 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: no Dr called in this case

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rupert Idaho

10. NAME OF FATHER: A. J. Powers

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Jessie Edwards

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Powers

(Address) Rupert Idaho

15.

Filed ..... 191.....

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191.....

that I last saw h..... alive on ..... 191.....

and that death occured on the date stated above, at ..... M

The CAUSE OF DEATH* was as follows:

Burned to death

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) No Physician M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence [redacted]

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: July 26 1914

20. UNDERTAKER: W. G. Gordman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka
City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jerrod F Small

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH. Feb (Month) 19 (Day) 1911 (Year)

7. AGE 3 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER G. F. Small

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER E. J. Nugent

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Small
(Address) .....

15.
Filed ..... 191....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1914, to Sept 12 1914, that I last saw h alive on Sept 12 1914, and that death occured on the date stated above, at 8 p. M.

The CAUSE OF DEATH* was as follows:
Tubercular meningitis

(Duration) ..... Yrs. 1 mos. ? ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Stevenson M. D.
1914 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Sept 13 1914
20. UNDERTAKER W. C. Goodwin	**ADDRESS** Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Minidoka

Primary Registration District No. 2102

File No.

City of Heyburn

(No. ....., ... St.)

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joel E. Sirrine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 20 (Day) 1869 (Year)

7. AGE: 45 yrs. 8 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Watermaster
(b) General nature of industry business, or dstablishment in which employed (or employer): Station'ary Engineer.

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Warren Sirrine

11. BIRTHPLACE OF FATHER (State or Country): New York City

12. MAIDEN NAME OF MOTHER: Esther Ann Emerson

13. BIRTHPLACE OF MOTHER (State or Country): New York City.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Caroline Sirrine
(Address) Heyburn Idaho

15.
Filed Aug. 12 1914 V. P. Killen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to July 4 1914, that I last saw h[illegible] alive on July 4 1914, and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Killen M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Ida.

DATE OF BURIAL: July 6th 1914.

20. UNDERTAKER: L. B. Gallogly

ADDRESS: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 2102
File No. 8847
Registered No. 4

1. PLACE OF DEATH.
County of Minnedoka
City of Heyburn (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1836 (Year)

7. AGE: 78 yrs. 10 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Jay Co. Indiana

10. NAME OF FATHER: Addington

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Jones
(Address) Heyburn

15.
Filed Sept. 10 1914 V. P. Killen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. 21 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 21 1914, to Aug - 21 1914, that I last saw her alive on Aug 21 1914, and that death occurred on the date stated above, at 11 50 M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis

(Duration) 8 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Killen M. D.
19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Ida — DATE OF BURIAL: Aug 22 1914

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66

Primary Registration District No. 2146

File No.

Registered No. 4

1. PLACE OF DEATH.

County of Latah

City of Bovill (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mato Simonovich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 1 (Day) 1888 (Year)

7. AGE: 26 yrs. 6 mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): lumbering P. L. Co.

9. BIRTHPLACE (State or Country): Montenegro

10. NAME OF FATHER: Melovan Simonovich

11. BIRTHPLACE OF FATHER (State or Country): Montenegro

12. MAIDEN NAME OF MOTHER: Juja Nacetuda

13. BIRTHPLACE OF MOTHER (State or Country): Montenegro

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andro Jokich
(Address) Bovill Ida

15. Filed Sept 14 1914 J. L. Champion Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1914, to Sept 10 1914, that I last saw h alive on Sept 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

accidental injury

(Duration) yrs. mos. ds.

Contributory (Secondary) Rolling log

(Duration) yrs. mos. ds.

(Signed) H. G. Gibson M. D.

19 (Address) Bovill Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bovill Ida — DATE OF BURIAL: 9/13 1914

20. UNDERTAKER: J. L. Champion — ADDRESS: Bovill Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CORP. & BDPS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Boviell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66
Primary Registration District No. 2146
(No. ....., ... St.)

File No. .....
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mamie Hughes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 10 (Day) 1900 (Year)

7. AGE: 14 yrs. 4 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. N. Hughes

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Lucy B. Smith

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Henry Smith
(Address) Boviell Ida

15. Filed Oct 7 1914 J L Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1914, to Sept 26 1914, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidentally Shot

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Rifle wound of neck

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A. Gibson M. D.
9/28 1914 (Address) Boviell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Boviell Ida | DATE OF BURIAL: 9/28 1914

20. UNDERTAKER: J L Thompson | ADDRESS: Boviell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK ... 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 57

Primary Registration District No. 2136

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3501

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel E. Bucher

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 18 (Day) 1901 (Year)

7. AGE: 13 Yrs. 2 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hard. A. Bucher

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Barbara Nuicks

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hard. A. Bucher
(Address) Montpelier Ida

15. Filed 9/16/ 1914 H. H. Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 13th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1914, to Sept 13 1914, that I last saw h[illegible] alive on Sept 13th 1914 and that death occured on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:
Scarlet Fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Don Poynter M. D.

9/15 1914 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 13 yrs. 2 mos. 2 days. In the State 13 yrs. 2 mos. 2 days

Where was disease contracted if not at place of death? .....

Former or usual residence Montpelier Idaho

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida. DATE OF BURIAL: 9/18/ 1914

20. UNDERTAKER: None ADDRESS .....

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5512
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier (No. ....., ... St.)

Registration District No. 57
Primary Registration District No. 2136

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Charles Anderegg

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Sept (Month) 7 (Day) 1914 (Year)
7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many 2.9 hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Montpelier
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country)
12. MAIDEN NAME OF MOTHER: Mary Anderegg
13. BIRTHPLACE OF MOTHER (State or Country): Bern Switz.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Mary Anderegg
(Address) Montpelier Idaho
15. Filed 9/8/ 1914 H. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 5 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1914, to Sept 8 1914
that I last saw h.. alive on Sept 8 1914
and that death occurred on the date stated above, at 19 M.
The CAUSE OF DEATH* was as follows: Suicide (Gunshot wound)

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) By Geo. [illegible] M. D.
9/8 1914 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier
DATE OF BURIAL: 9/8 1914
20. UNDERTAKER: none
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2106
(No. ....., ... St.)

File No. 3
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Braundenberger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Don't Know 1
(Month) (Day) (Year)

7. AGE about 60 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Byron Nelson
(Address) Montpelier

15. Filed 9/5/ 1914 W. H. Kingsbury Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 3 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30. 1914 to Sept 3 1914, that I last saw h[illegible] alive on Sept 2 1914 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Arterial Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Byron M. D.
9/3 1914 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Montpelier — DATE OF BURIAL 9/4/1914

20. UNDERTAKER None — ADDRESS —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8854
Registered No.

1. PLACE OF DEATH. Registration District No. 52
County of Bear Lake
City of Montpelier (No. ....., ... St.)
Primary Registration District No. 2136

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Bagley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 21st (Day) 1846 (Year)

7. AGE: 69 yrs. 11 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: A. J. Allen

11. BIRTHPLACE OF FATHER (State or Country): Kentucky A. J. Allen

12. MAIDEN NAME OF MOTHER: Delelah C. Allen

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Bagley Jr.
(Address) Montpelier Ida.

15. Filed 9/4/1914 H. H. Ring Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 2d (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1914., to Sept 2nd 1914 that I last saw her alive on Sept 1st 1914 and that death occurred on the date stated above, at 5-30 P. M.

The CAUSE OF DEATH* was as follows: (Unknown)
Senility

(Duration) 5 yrs. — mos. — ds.
Contributory (Secondary) Fatty Degeneration of Heart
Dont Know
(Duration) 3 yrs. — mos. — ds.

(Signed) E. F. Lueyen M. D.
9/4 1914 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida
DATE OF BURIAL: 9/4 1914

20. UNDERTAKER: None
ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Glens Ferry (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2024

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Hugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Oct (Month) — (Day) 1870 (Year)

7. AGE: 44 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Wm Hugh

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Ann Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. Hugh Jr
(Address): Mowdy Mich

15.
Filed Sept. 30 1914 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 22nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Drowned in Snake River
near Bliss, Idaho

(Duration) — yrs. — mos. — ds.

Contributory (Secondary): not known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. H. Eaton Coroner M. D.
19... (Address) Mtn Home, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? not known
Former or usual residence: Not known

19. PLACE OF BURIAL OR REMOVAL: Mowdy Mich
DATE OF BURIAL ..... 191...

20. UNDERTAKER: J. M. Corson
ADDRESS: Mtn Home Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No.
(No. , St.)

File No.
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Massey Dearfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widowed

6. DATE OF BIRTH: March 5 1827 (Month) (Day) (Year)

7. AGE: 87 yrs. 6 mos. 1 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid For 20 yrs.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: J Martin

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O S Dearfield
(Address) Kimberly Ida

15.
Filed Sept. 7 1914 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1914, to Sept 6 1914, that I last saw her alive on Sept 5 1914, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Old Age

(Duration) yrs. mos. ds.
Contributory (Secondary) Intestinal Intoxication
(Duration) yrs. mos. 3 ds.

(Signed) J. M. Davis M. D.
Sept 7 1914 (Address) Kimberly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. Ida. | DATE OF BURIAL: Sept 8 1914
20. UNDERTAKER: J. J. Freeman | ADDRESS: Twin Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 10

1. PLACE OF DEATH.
County of Nez Perce
City of Gifford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

2. FULL NAME Silas A Stevens

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 16 (Day) 1866 (Year)

7. AGE: 48 yrs. 6 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Jason Butler

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary Jerlds

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. O. Hayden
(Address) Gifford

15.
Filed 9-10 1914
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-15 1913, to 1-13 1914
that I last saw her alive on 1-13 1914
and that death occurred on the date stated above, at 11 30 a. M.

The CAUSE OF DEATH* was as follows:
Sarcoma

(Duration) — yrs. 11 mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.
9-10 1914 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lookout Ida
DATE OF BURIAL: 9-12 1914

20. UNDERTAKER: T. Fels (acting)
ADDRESS: Baldwin.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Juliaetta

Registration District No.
Primary Registration District No. 2148
(No. , St.)

File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elva Kehrman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: (Month) June (Day) 27 (Year) 1914

7. AGE: yrs. 1 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Juliaetta Ida

10. NAME OF FATHER: John Kehrman

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin.

12. MAIDEN NAME OF MOTHER: Hattie Wick

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Kehrman
(Address) Juliaetta Ida

15.
Filed Aug 7 1914
S A Roe.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: (Month) Aug. (Day) 5 (Year) 1914

17. I HEREBY CERTIFY, That I attended deceased from June 27 1914, to Aug. 1 1914
that I last saw her alive on Aug 1 1914
and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. ds.

Contributory (Secondary) Premature birth.

(Duration) yrs. mos. ds.

(Signed) S A Roe M. D.
8/7 1914 (Address) Juliaetta Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Ida.
DATE OF BURIAL: Aug 6 1914

20. UNDERTAKER: J. C. Groseclose
ADDRESS: Juliaetta Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Juliaetta

Registration District No.
Primary Registration District No. 2148
(No. , St.)

File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elvina Hehman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: June (Month) 27 (Day) 1914 (Year)

7. AGE: yrs. 1 mos. 13 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Juliaetta, Ida

10. NAME OF FATHER: John Hehman

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Hattie wilk

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Hehman
(Address) Juliaetta Ida.

15.
Filed Aug 9 1914 S.A.Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1914, to Aug 1, 1914
that I last saw her alive on Aug 1 1914
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature birth.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S.A.Roe M. D.

Aug 9 1914 (Address) Juliaetta Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Ida. DATE OF BURIAL: Aug 10 1914

20. UNDERTAKER: J.C. Rosedale ADDRESS: Juliaetta Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2904
(No. ....., ... St.)

File No. 8861
Registered No. 97

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Casmere York

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
Apr (Month) 22 (Day) 1822 (Year)

7. AGE
92 Yrs. 4 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. C. York
(Address) Harrison Ida.

15.
Filed Oct 6 1914
R. S. Jensen
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw him alive on Aug 4 1914
and that death occured on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Valvular heart disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Unger M. D.
Sept 11 1914 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Id — DATE OF BURIAL: 9/11 1914

20. UNDERTAKER: Ewen Neeley — ADDRESS: Harrison Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. ____

Registered No. 26

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 9204
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Frank Daniels.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: June (Month) 18 (Day) 1914 (Year)

7. AGE: 9 yrs. 9 mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ____
(b) General nature of industry business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Kootenai Co. Idaho.

10. NAME OF FATHER: Walter Daniels.

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Myrtle Wolbe.

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Daniels.
(Address) Harrison

15. Filed Oct 6 1914 R.S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1914, to Sept 10 1914
that I last saw him alive on Sept 10 1914
and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Gastroenteritis

(Duration) ____ yrs. ____ mos. 10 ds.

Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. M. Stevens M. D.
Sept 11 1914 (Address) Harrison Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted, if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Harrison Id
DATE OF BURIAL: 9/12 1914

20. UNDERTAKER: Everhardt
ADDRESS: Harrison

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 1
Registered No. 22

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Hayden Hibbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (write the word.)

6. DATE OF BIRTH: Oct 5 (Month) (Day) 1890 (Year)

7. AGE: 24 yrs. 9 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: John Hayden

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Anna Enno

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Hibbert
(Address) Aberdeen

15. Filed Sept 14 1914 M. C. Mackinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1914, to Sept 10 1914, that I last saw her alive on Sept 10 1914, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal Septicaemia

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) M. C. Mackinnon M. D.
Sept 14 1914 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Fremont Cemetery — DATE OF BURIAL: Sept 23 1914

20. UNDERTAKER: Acting Will Bartel — ADDRESS: Aberdeen Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Arco
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

File No. 17
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Wallace Harvey Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November (Month) 25 (Day) 1870 (Year)

7. AGE: 45 yrs. 10 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: David Brown

11. BIRTHPLACE OF FATHER (State or Country): Mexico, Maine

12. MAIDEN NAME OF MOTHER: Abba Anna Flagg

13. BIRTHPLACE OF MOTHER (State or Country): Canton Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rhoda Brown
(Address) Arco, Idaho

15. Filed 9/21 1914 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/14 1917, to 9-17 1914 that I last saw h[illegible] alive on 9-17 1914 and that death occurred on the date stated above, at 9.50 P.M.

The CAUSE OF DEATH* was as follows:
Double Lobar Pneumonia
.....
.....
..... (Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Chronic Appendicitis
..... (Duration) 2 yrs. ..... mos. ..... ds.
(Signed) E W Fox M. D.
9/21 1914 (Address) Arco

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho
DATE OF BURIAL: 9-19 1914

20. UNDERTAKER: E. J. Peck
ADDRESS: Blackfoot, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Vallmer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 50
Primary Registration District No. 2129
(No. ....., ... St.)

File No. 8865
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud Belle McLean

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: May (Month) 22 (Day) 1882 (Year)

7. AGE: 32 yrs. 3 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Josiah Fuller

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Martha Balch

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J A McLean
(Address) Vallmer Idaho

15.
Filed Sept 4 1914 H C Parrish
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
September (Month) 3d (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1914, to Sept 4th 1914, that I last saw her alive on Sept 4th 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Uremic Coma
(Secondary)
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) E L Burdg M. D.
9-4 1914 (Address) Vallmer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. 1 mos. — days. In the State 5 yrs. 2 mos. 21 days.
Where was disease contracted if not at place of death?
Former or usual residence Elbe Wash

19. PLACE OF BURIAL OR REMOVAL: Gibert. Idaho. DATE OF BURIAL: Sept 5 1914

20. UNDERTAKER: Star Hdw & Imp Co ADDRESS: Mo Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 50

County of Gem

Primary Registration District No. 2129

City of Vollmer (No. ..... St.)

File No. .....

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sabry Allis Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1914 (Year)

7. AGE: 56 yrs. 7 mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Baren Co Ky

10. NAME OF FATHER: Warren Phillips

11. BIRTHPLACE OF FATHER (State or Country): Green Co Ky

12. MAIDEN NAME OF MOTHER: Evaline Bowles

13. BIRTHPLACE OF MOTHER (State or Country): Baren Co Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Banks
(Address) Vollmer Idaho

15.
Filed Sept 27 1914 H. C. Parrish
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1914, to Sept 26 1914, that I last saw h... alive on Sept 20 1914, and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

not known
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): none
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Burke M. D.

9-27 1914 (Address) Vollmer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. cemetary — DATE OF BURIAL: Sept 27 1914

20. UNDERTAKER: Star Hdw & Impl Co — ADDRESS: Mo Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 93

Primary Registration District No. 2171

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perces

City of Pedro

2. FULL NAME Allen Cecil Hardman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 7 (Month) 12 (Day) 1914 (Year)

7. AGE ....Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER A. C. Hardman

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Jennie M. Baker

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. M. Lyle

(Address) Pedro

15. Filed 10-1 1914

J. M. Lyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1914, to Sept 25 1914, that I last saw him alive on above date 1914, and that death occured on the date stated above, at 1a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J. M. Lyle M. D.

Sept 27 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Central Ridge Cemetery — DATE OF BURIAL: 9/27 1914

20. UNDERTAKER: None — ADDRESS: -

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Peck
Registration District No. 13
Primary Registration District No. 2171
(No. ....., ... St.)
File No. .....
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morris Phelpot

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept. (Month) 25 (Day) 1912 (Year)

7. AGE: 1 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wn

10. NAME OF FATHER Thomas H. Phelpot

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Coburn

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas H. Phelpot.
(Address) Peck - Ida

15. Filed Sept. 21 1914 J. M. Lyle Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Was dead when I arrived. Cause very uncertain Sick about 20 hours
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Lyle M. D.
9/22 1914. (Address) Peck

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gilbert Ida — DATE OF BURIAL: 9-22 1914

20. UNDERTAKER: None — ADDRESS: -

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16

County of Butte

Primary Registration District No.

File No. 8869

City of McCall

(No. , St.)

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Maki

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Month & Day unknown (Month) (Day) 1849 (Year)

7. AGE: 65 yrs. unknown mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Finland.

12. MAIDEN NAME OF MOTHER: Unknown to informant

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Lacouvaara
(Address) McCall

15.
Filed July 28 1914 Ruth McDonald
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1914, to July 27 1914, that I last saw her alive on July 27 1914, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(Duration) yrs. mos. ds.

Contributory (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) J. W. Compton M. D.

July 28 1914 (Address) McCall

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nels Wargelin — DATE OF BURIAL: July 29th 1914

20. UNDERTAKER: John Lacouvaara — ADDRESS: McCall

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Boise

City of McCall.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. ....., ... St.)

State of [illegible]
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8870

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tilda Maggie Walin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 1 (Day) 1870 (Year)

7. AGE: 44 Yrs. Sept Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finnland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Tilda Maggie Maki

13. BIRTHPLACE OF MOTHER (~~State~~ or Country): Finnland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Walin

(Address) McCall

15. Filed Sept 25 1914 Ruth McDonald Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Cancer

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) No Physician M. D.

Sept 1914 (Address) Herman Walin

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL: Sept 26th 1914

20. UNDERTAKER: D. M. Col | ADDRESS: Boseberry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & BDRS. 24654

8871

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 58
County of Blaine Primary Registration District No. 2138
City of Saldin (No. ..., ... St.)
File No. 8871
Registered No. 13
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Hans Pilsman
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: June (Month) 17 (Day) 1871 (Year)
7. AGE: 43 yrs. 3 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work: Stone mason
(b) General nature of industry business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Valentina Hinrud
(Address) Conrad
15.
Filed 9-29 1914 D. O. Higgins M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 8-16-1914, to 9-28 1914
that I last saw him alive on 9-28 1914,
and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) ... yrs. 10 mos. ... ds.
Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.
(Signed) D. O. Higgins M. D.
9-29 1914 (Address) Saldin

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Saldin Ida — DATE OF BURIAL: 9-30 1914
20. UNDERTAKER: Liz Morrell — ADDRESS: Saldin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

BYRNES-YORK CO., PRINTERS & BINDERS, BOISE 10672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 49

Primary Registration District No. 2128

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Caribel (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Elva) Elva Ray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	

6. DATE OF BIRTH

April (Month) 12 (Day) 1912 (Year)

7. AGE

1 yrs. 5 mos. 13 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Winchester, Idaho

10. NAME OF FATHER Truman A Ray

11. BIRTHPLACE OF FATHER (State or Country) Owensboro, Ky

12. MAIDEN NAME OF MOTHER Jessie Lowe

13. BIRTHPLACE OF MOTHER (State or Country) Neosho, Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Truman A Ray

(Address) Caribel Idaho

15.

Filed 9/26 1914 W. J. McMahon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 25, 1914 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10th 1914, to Sept 25th 1914, that I last saw h[illegible] alive on Sept 23rd 1914, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Intracellitis

(Duration) yrs. mos. 15 ds.

Contributory (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) C. J. Burgan M. D.

9/26 1914 (Address) Hamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Good Cemetery — DATE OF BURIAL: 9/26 1914

20. UNDERTAKER: C. J. Johnson — ADDRESS: Hamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 8873
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Corena M Brotchers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 18 (Day) 1897 (Year)

7. AGE: 17 Yrs. 9 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J.H. Lobb

11. BIRTHPLACE OF FATHER (State or Country): Dont know.

12. MAIDEN NAME OF MOTHER: Trufena Wagner

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W Brotchers
(Address) Nampa Ida

15. Filed Sept 19 1914 Dr S D Calouge Local Registrar
Nampa Kaufield

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1914, to Sept 18 1914, that I last saw her alive on Sept 18 1914, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Drank Three ounces of Chloroform with suicidal intent
(Duration) 30 hours Yrs. mos. ds.
Contributory (Secondary) —
(Duration yrs. mos. ds.
(Signed) J T Murray M. D.
Sept 17 1914 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: 9-20 1914

20. UNDERTAKER: E K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. .....
Registered No. 53
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Katherine R Fulmer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 1 (Day) 1883 (Year)

7. AGE: 30 yrs. 11 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ryburg Idaho

10. NAME OF FATHER: John L Roberts

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Dodge

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest D Fulmer
(Address) Salem (By JR Bymm)

15. Filed 9-11 1914 G G Cope Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1914, to Sept 5 1914, that I last saw her alive on Sept 5 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobular and Edema
Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory
(Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Bymm M. D.
1914 (Address) Ryburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar — DATE OF BURIAL: 9/7 1914

20. UNDERTAKER: J R Bymm — ADDRESS: Ryburg

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rubland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 8876
Registered No. 54
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nils Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) 27 (Day) 1853 (Year)

7. AGE: 60 yrs. 10 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: James Anderson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Catherine Anderson
(Address) Rubland

15. Filed 10-2 191[illegible]
G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20 1914, to Sept. 21 1914, that I last saw him alive on Sept. 21 1914, and that death occurred on the date stated above, at 6 9 M.

The CAUSE OF DEATH* was as follows:
Nephrolithiasis

(Duration) ? yrs. ? mos. ? ds.
Contributory (Secondary) Shock
(Duration) ..... yrs. ..... mos. 1½ ds.
(Signed) J. H. Wagner M. D.
Sept 7 1914 (Address) Rexburg, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rubey — DATE OF BURIAL: 10/1/14 191[illegible]

20. UNDERTAKER: [illegible] Rexburg — ADDRESS: Rubey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 4-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Replogle
City of
(No. , St.)

Registration District No. 100
Primary Registration District No. 2178

File No.
Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kathaline Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH. Sept (Month) 20 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 7 days. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. R. Larson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Katie Saunders

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Fred Saunders
(Address) Replogle

15. Filed 9-21 191X Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) 21 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-20 191X, to 9-21 191X, that I last saw h[illegible] alive on 9-20 191X, and that death occured on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:
Premature

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 191

20. UNDERTAKER	ADDRESS
none	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

DYNO - YORK CO., PTRS. & PUBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 8878
Registered No. 36

1. PLACE OF DEATH.
County of Madison
City of Replevy (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold B. Watson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb. (Month) 27 (Day) 1914 (Year)

7. AGE ..... Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Byrus N. Watson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Anna M. Burke

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Burke
(Address) Replevy

15. Filed 9-22 1914 G. L. Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-14 1914, to 9-21 1914, that I last saw him alive on 9-21 1914, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Toxaemia following Intussusception

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. L. Estes M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 9/23 1914

20. UNDERTAKER: John Phillips — ADDRESS: Replevy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Clarkefork
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

File No. .....
Registered No. 548
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edney E. Hurlburt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1846 (Year)

7. AGE: 67 yrs. 11 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York Stat

10. NAME OF FATHER: Forest Hurlburt

11. BIRTHPLACE OF FATHER (State or Country): New York Stat

12. MAIDEN NAME OF MOTHER: Letty Hopson

13. BIRTHPLACE OF MOTHER (State or Country): New York Stat

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William E. Hurlbut
(Address) Clarkefork Idaho

15. Filed Oct 7 1914 W. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8th 1914, to Sept 16th 1914, that I last saw him alive on Sept 14th 1914, and that death occurred on the date stated above, at 3-30 P.M.

The CAUSE OF DEATH* was as follows:

Primary Obstruction of Gall Ducts
Secondary Mitral Disease of Heart.

(Duration) ..... yrs. One mos. Seven ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Arthur L. Salmon M. D.
Sept 17th 1914 (Address) Clarkefork Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkefork Ida — DATE OF BURIAL: 9/18 1914

20. UNDERTAKER: E M Brown — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

M. McKinnon.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

File No. .....
Registered No. 549
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James Newman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 18 (Day) 1879 (Year)

7. AGE: 35 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): Homestead

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: William Newman

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Bagnely

13. BIRTHPLACE OF MOTHER (State or Country): Dalles Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Burgess Ashley
(Address) St Ignatius Mont.

15.
Filed Oct 8 1914 M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1914, to Sept 20 1914, that I last saw him alive on Sept 19 1914, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Kidneys

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. McKinnon M. D.
Sept 21 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, ~~Institutions, Transients or Recent Residents.~~)
At place of death ..... yrs ..... mos 3 ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Mont.
DATE OF ~~BURIAL~~: 9/22 1914

20. UNDERTAKER: E M Brown
ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Priest River
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153
(No. ..... St.)

File No. 8881
Registered No. 550
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME M. Cody

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Single

6. DATE OF BIRTH
July 12" (Month) (Day) 1858 (Year)

7. AGE
56 yrs. 2 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Laborer
(b) General nature of industry business or establishment in which employed (or employer) ... —

9. BIRTHPLACE (State or Country) Halifax. N.S. Canada

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H W. Didier
(Address) Priest River Ida

15.
Filed Oct 8 1914 M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1914, to Sept 21 1914 that I last saw him alive on Sept 21 1914, and that death occurred on the date stated above, at 4 30 P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ... yrs. ... mos. 15 ds.
Contributory (Secondary) Tuberculosis
(Duration) 2 yrs. — mos. — ds.

(Signed) H W Didier M. D.
Sept 22 1914 (Address) Priest River Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 11 ds. In the State — yrs. 1 mos. — ds.
Where was disease contracted, if not at place of death? Dalkena Logging Camp
Former or usual residence Missoula Mont (Hospital)

19. PLACE OF BURIAL OR REMOVAL Sandpoint Ida — DATE OF BURIAL 9/28 1914

20. UNDERTAKER E W Brown — ADDRESS Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

IVMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2153

City of Hope

(No. ....., ... St.)

File No. .....

Registered No. 551

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wong Jayung

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Yellow	Single

6. DATE OF BIRTH ..... (Month) ..... (Day) 1845 (Year)

7. AGE 69 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) China

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W M Knapp M D
(Address) Hope (Coroner

15.
Filed Oct 8 1914 M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191 ..... to ..... 191 ....., that I last saw h[illegible] was seen alive on Sept 21 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Alcoholism
Verdict of Coroner
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M. Knapp M. D.
9/23 1914 (Address) Hope Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL E M Brower | DATE OF BURIAL Sep 23 1914

20. UNDERTAKER Sand Point | ADDRESS Hope

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M-(1911)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

STATE OF IDAHO
Registration District No. 28
Subdistrict Registration District No. 0153
File No. 6813

City of Kootenai (No. ....., ... St.) Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gottfried Fonkhauser

If death occurred in a hospital, institution or camp give NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Dec (Month) ..... (Day) 1911 (Year)

7. AGE: 7 yrs. 4 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: occupation of father
(b) General nature of industry business, or establishment in which employed (or employer): carpenter.

9. BIRTHPLACE (State or Country): Tirol Austrea.

10. NAME OF FATHER: Gottfried Fonkhauser

11. BIRTHPLACE OF FATHER (State or Country): Tirol Austria

12. MAIDEN NAME OF MOTHER: Amalia Hamerle

13. BIRTHPLACE OF MOTHER (State or Country): Tirol Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Gottfried Fonkhauser
(Address): Kootenai Idaho

15. Filed Oct 8 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 26 1914, to Sept. 27 1914, that I last saw him alive on Sept. 27 1914, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Acute Lymphatic Leukaemia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Acute Eruptive Fever not seen by me

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C B Bateman M. D.
Oct. 6 1914 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: 9/30 1914

20. UNDERTAKER: E M Brower — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exa ment of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE-YORK CO., PRINTERS & BINDERS. BOISE 16172

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 546

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ....., ... St.)

Registration District No. 78
Primary Registration District No. 2103

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME F. P. Bickett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 36 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Anthony L Bickett

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Elva Renfro

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Bickett
(Address) Elmo Mont

15. Filed Oct 8 1914 M McKinney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 1st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1914, to Aug 31 1914, that I last saw h alive on Aug 31 1914 and that death occurred on the date stated above, at 6 PM.

The CAUSE OF DEATH* was as follows: Pneumonia, Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M M McKinney M. D.

9/3 1914 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Cascade Mont. DATE OF ~~BURIAL~~: 9/3 1914

20. UNDERTAKER: E M Brower ADDRESS: Sandpoint Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.
County of Bonner
City of Laclede
Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 547
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME. E. Herman Ericson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1872 (Year)

7. AGE: 42 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Sawyer
(b) General nature of industry business or establishment in which employed (or employer) Logging

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Carl Eric Ericson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Allen
(Address) Laclede

15. Filed Oct 8 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September 12 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10 1914, to Sept. 12 1914
that I last saw him alive on Sept. 12 1914
and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:

Accidental injury by falling tree.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. A. Allen M. D.
Sept 12 1914 (Address) Laclede Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: 9/16 1914

20. UNDERTAKER: E. M. Brown — ADDRESS: S.P.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 2119

City of Preston (No. ....., ... St.)

File No. .....

Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Mozart Burgi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 18 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Franklin Co.

10. NAME OF FATHER George E Burgi

11. BIRTHPLACE OF FATHER (State or Country) Midway Utah

12. MAIDEN NAME OF MOTHER Emily Smith

13. BIRTHPLACE OF MOTHER (State or Country) Kansas Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo E. Burgi
(Address) .....

15. Filed Oct 9 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1914, to Oct 3 1914 that I last saw him alive on Oct 2 nd 1914 and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) — yrs. — mos. 5 ds.

Contributory —
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen D Bullen M. D.

19 .... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: Oct. 5 1914

20. UNDERTAKER: W. A. Gidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2119
(No. 6, ... St.)

File No. .....
Registered No. 43
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clyde Wm Ballinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH
July (Month) 1 (Day) 1876 (Year)

7. AGE
38 yrs. 2 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Kansas

10. NAME OF FATHER
Jerry Ballinger

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER
Eloise E. Wadsworth

13. BIRTHPLACE OF MOTHER
(State or Country) U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Clyde Ballinger
(Address) Preston Idaho.

15.
Filed 10/9 1914 Allen Rowe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept 30th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidently drounded

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Meyer Coroner M. D.
Sep 30 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS
C. C. Sandgrind | Logan Utah.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 269

City of Preston (No. ....., ... St.)

File No. 8890

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Elnora Harding

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct. (Month) 22 (Day) 1869 (Year)

7. AGE: 44 yrs. 10 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Franklin Idaho

10. NAME OF FATHER: William Hardy

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Day

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. W. Harding
(Address) Preston

15. Filed Nov 7 1914 Dr. Alvah R. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 9 1914, to Sept. 14 1914, that I last saw her alive on Sept. 12 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alvah R. Cutler M. D.

19 ..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Ida | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: W. A. Gidmore | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ....., ... St.)

File No. .....

Registered No. 47

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johanna Maria Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. ~~SINGLE, MARRIED~~, WIDOWED ~~OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH: May (Month) 13 (Day) 1836 (Year)

7. AGE: 78 yrs. 4 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: General Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Nelson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Annie Davis

(Address) .....

15.

Filed Oct 9 1914 — Allan R Pullin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1914, to Sept 22 1914

that I last saw h.. alive on Sept 19 1914 about 8 A.M.

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found dead at home with
Signs of having bled to death
from lungs — was not sick
the day before

(Duration) ..... yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allan R Pullin M. D.

19.... (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: Sept 22 1914

20. UNDERTAKER: W G Isaacson — ADDRESS:

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

Primary Registration District No. 1011

File No.

County of Latah

City of Moscow (No. 807, Lynn & Mabelle Ave., St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME E. A. Maria Kullberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female.	White	

6. DATE OF BIRTH: April (Month) 24 (Day) 1901 (Year)

7. AGE: 13 yrs. 5 mos. 11 ds.

IF LESS than 1 day how many .....*hrs. or* .....*mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jönköping Sweden

10. NAME OF FATHER: Mr. K. Kullberg.

11. BIRTHPLACE OF FATHER (State or Country): Wäxio Sweden

12. MAIDEN NAME OF MOTHER: Anna Kullberg.

13. BIRTHPLACE OF MOTHER (State or Country): Wäxio Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr K Kullberg.

(Address) Cor. of Lynn & Mabelle Ave.

15.

Filed Oct. 6 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4th 1914 to Oct 4th 1914, that I last saw her alive on oct 4th 1914 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) / yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Adam M. D.

Oct 6 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Oct 7 1914

20. UNDERTAKER: Geo Kleth | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. .....
Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth A. Peasley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug. (Month) 29 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 10 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow Idaho

10. NAME OF FATHER: Frank S. Peasley

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Rubie L. Hardrick

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank S Peasley
(Address) Moscow Idaho

15. Filed Sept 8 1914 — D. F. Rees, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191....
that I last saw h..... alive on Sept 6 1914
and that death occurred on the date stated above, at 12-30 P M.
The CAUSE OF DEATH* was as follows:
Malnutrition

..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. N. Clarke M. D.
..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Sep 9 1914

20. UNDERTAKER: Geo Stelly — ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
File No. ...
Registered No. 56
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Loyd Glenn Sheets

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	White	

6. DATE OF BIRTH: March (Month) 21 (Day) 192 (Year)

7. AGE: 12 yrs. 6 mos. 10 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow

10. NAME OF FATHER Wm Sheets

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Laura Frazee

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laura Sheets
(Address) Moscow

15. Filed Sept 12 1914 F. F. Carr Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 11" (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1" 1914, to Sept. 11" 1914, that I last saw him alive on Sept. 11" 1914, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Tetanus, Following an extensive injury to right fore-arm.
(Duration) ... yrs. ... mos. 11 ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. F. Carothers M. D.
19 (Address) Moscow, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 11 days. In the State Lifetime yrs. ... mos. ... days.
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Sept. 13 1914

20. UNDERTAKER: Stelty — ADDRESS: Moscow Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

61

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1011
(No. , St.)

File No.
Registered No. 535
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Judith Dalseth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Aug (Month) 29 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Moscow

10. NAME OF FATHER Jens L Dalseth

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Effie Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jens L Dalseth
(Address) Moscow

15. Filed Sep 14 1914 S. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 13th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1914, to Sept 13th 1914, that I last saw her alive on Sept 8th 1914, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Mal Nutrition
(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Cram M. D.
Sept 14 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Sep 14 1914

20. UNDERTAKER: Wm Drummond & Son — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

Primary Registration District No. 1011

File No.

County of Latah

City of Moscow (No. , St.)

Registered No. 5-4

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	

6. DATE OF BIRTH: July (Month) 5 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 9 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chris Peterson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Regina S Svenson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chris Peterson
(Address) Moscow Idaho

15. Filed Sept 14 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1914, to Sept 13 1914, that I last saw h[illegible] alive on Sept 11 1914 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Asprey M. D.
Sept 14 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Sept 15 1914

20. UNDERTAKER: Crow — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. .....
Registered No. 52
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice E Cole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fm	W	Married

6. DATE OF BIRTH
May (Month) 13 (Day) 1871 (Year)

7. AGE
53 yrs. 4 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Wisconsin

10. NAME OF FATHER James Stanley

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Est of J Jessup
(Address) Bathwood Ida

15.
Filed Sept 18 1914 S F Bae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 15 1914 to Sept 18 1914
that I last saw him alive on Sept 11 1914
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Tubercular Peritonitis

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Clarke M. D.
19 .... (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moscow — DATE OF BURIAL Sept 19 1914

20. UNDERTAKER Geo Steele — ADDRESS Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

Item of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. .....
Registered No. 5-72
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria M. Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: August 31st 1840 (Month) September (Day) 26 (Year) 1914

7. AGE: 74 yrs. mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): House Wife

9. BIRTHPLACE (State or Country): State of Ohio

10. NAME OF FATHER: Isac Holderman

11. BIRTHPLACE OF FATHER (State or Country): State of Ohio

12. MAIDEN NAME OF MOTHER: Harriet Rawlse

13. BIRTHPLACE OF MOTHER (State or Country): State of Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W G Barge
(Address) Moscow, Idaho

15. Filed Sept 28 1914 W F Rea Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1913., to Sept. 1914, that I last saw her alive on Sept. 20th 1914 and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:
Paralysis following Apoplexy

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Carothers M. D.
9-28 1914 (Address) Moscow Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Sept 28 1914

20. UNDERTAKER: Lee Stotz — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 40
Primary Registration District No. 2166
(No. ..... St.)
File No. .....
Registered No. 40
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME C. E. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... 1871 1
(Month) (Day) (Year)

7. AGE
43 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Printer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Not known

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. W. Givens
(Address) Orofino, Ida.

15. Filed Aug 15 1914 ✓ Moore ✓ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August 3rd, 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1914, to Aug. 3, 1914, that I last saw him alive on Aug. 2, 1914, and that death occurred on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Insanity

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Johnson Givens M. D.

Aug 3 1914 (Address) Orofino Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. ..... mos. 18 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Orofino, Ida. | DATE OF BURIAL Aug 5, 1914

20. UNDERTAKER Caldwell & Hall | ADDRESS Orofino, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

File No. [illegible]

County of Clearwater

City of Orofino (No. , St.)

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Dwyer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: About 1859 (Month) 1 (Day) (Year)

7. AGE: About 55 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): County charge

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno N. Givens

(Address) Orofino, Ida

15. Filed Sept 18 1914 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 25, 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 4th 1914, to Aug. 25, 1914, that I last saw h[illegible] alive on Aug. 25 1914, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(Duration) yrs. mos. ds.

Contributory (Secondary): Insanity

(Duration) 4 yrs, mos. ds.

(Signed) John N. Givens M. D.

Aug 25 1914 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 7 mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Orofino Idaho — DATE OF BURIAL: Aug. 27 1914

20. UNDERTAKER: Clarence R. Hill — ADDRESS: Orofino, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 16760

Form V. S. No. 5 20M.1-16-12

State of Idaho
DEPARTMENT OF HEALTH
Bureau of Vital Statistics

Registration District No. 90

Primary Registration District No. 2158

File No. 6901

Registered No. 42

1. PLACE OF DEATH.

County of Clearwater

City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John McChandler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	Married

6. DATE OF BIRTH

Apr (Month) 1 (Day) 1831 (Year)

7. AGE

83 yrs. mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER James McChandler

11. BIRTHPLACE OF FATHER (State or Country) Ken

12. MAIDEN NAME OF MOTHER Kundy

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. Chandler

(Address) Orofino Ida

15. Filed Oct 1 1914 J. McFarley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1914, to Sept 6 1914, that I last saw h alive on Sept 6 1914 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) Acute Catarrhal Jaundice

(Duration) yrs. mos. 8 ds.

(Signed) J. McFarley M. D.

Oct 7 1914 (Address) Orofino Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida — DATE OF BURIAL: Oct 8 1914

20. UNDERTAKER: W. C. Stoddard — ADDRESS: Gifford Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Clearwater

Primary Registration District No. 2168

City of Orofino

(No. ..... St.)

File No. .....

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. F. Fuller

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~ divorced

6. DATE OF BIRTH: 1844 (Month) 1 (Day) (Year)

7. AGE: 70 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno W. Givens
(Address) Orofino, Ida

15. Filed Oct 6 1914 J. M. Faris Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September 13th. 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1914, to Sept. 13 1914, that I last saw h alive on Sept. 13 1914, and that death occurred on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:
Alcoholism

(Duration) 20 yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) John W. Givens M. D.
Sept. 15 1914 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 days. In the State 7 yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? U.S.

Former or usual residence U.S.

19. PLACE OF BURIAL ~~OR REMOVAL~~: Orofino, Ida. DATE OF BURIAL: Sept. 17. 1914.

20. UNDERTAKER: Clarence R. Hill ADDRESS: Orofino Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2077
File No.
Registered No. 18

1. PLACE OF DEATH.
County of Blaine
City of Ketchum
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A Anderson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: About 57 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Saloonkeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas H Bowersox
(Address) Ketchum Ida

15. Filed Sept 25 1914 Robert H Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Robert H. Wright M. D.
19.... (Address) County Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ketchum Ida
DATE OF BURIAL: Sept 27 1914

20. UNDERTAKER: R. D. Harris
ADDRESS: Hailey Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 8903

Name John A. Anderson

Date of Death September 17, 1914

Cause of Death ~~Heart failure~~ Alcoholism

Contributary Cause of death Chronic Alcoholism

(Sign here) Robert H. Smyth, M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine Co. Registration District No. 21
City of Carey (No. ....., ... St.) Primary Registration District No. 2075
If death occurs away from usual residence, give facts called for under special information.

File No. .....
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florence Alice Schaffer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female.	White.	

6. DATE OF BIRTH: Sept. (Month) 15th (Day) 1914 (Year)

7. AGE: — yrs. 2 mos. 5 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Carey.

10. NAME OF FATHER W. M. Shaffer.

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Alice Coleman

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. A. Shaffer.
(Address) Carey Ida.

15. Filed Sept 18 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to ..... 191..., that I last saw h— alive on ..... 191..., and that death occurred on the date stated above, at 10-55 A M.

The CAUSE OF DEATH* was as follows:
Premature Birth
—
—
(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
Sept 18 1914 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bancroft Ida. DATE OF BURIAL: Sept 18 1914

20. UNDERTAKER: R. D. Harris ADDRESS: Rexburg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 414, 2nd ave St.)

File No.
Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Frank B Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1845 (Year)

7. AGE: 69 yrs. 11 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Capitol City Lawyer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: John P Wells

11. BIRTHPLACE OF FATHER (State or Country): New Hampsh

12. MAIDEN NAME OF MOTHER: Miss W Putney

13. BIRTHPLACE OF MOTHER (State or Country): N.H.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Shotwell M.D.
(Address) Lewiston

15. Filed Oct. 10 1914 L.J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 9 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to Sept-9 1914
that I last saw h alive on Sept 9 1914
and that death occurred on the date stated above, at 8.45 M.

The CAUSE OF DEATH* was as follows:
Chronic Duodenal Ulcer

(Duration) 4 yrs. mos. ds.
Contributory (Secondary) Hemorrhage
(Duration) yrs. mos. 10 ds.

(Signed) C W Shotwell M. D.
Sept 9 1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake. Utah
DATE OF BURIAL ..... 191...

20. UNDERTAKER: L. Larson
ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 96

County of Nez Perce Primary Registration District No. 1009

City of Lewiston (No. Hospital St.)

File No.

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. E. Norberg.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: — (Month) — (Day) 1848 (Year)

7. AGE: 65 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Peter Norberg.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Sofi Knowers

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emily E. Norberg
(Address) City.

15. Filed Oct. 10 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 13 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1914, to Sept 13 1914, that I last saw h alive on Sept 14 1914 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Edwema Bright's Disease

(Duration) N yrs. mos. ds.
Contributory (Secondary) Arteriio Sclerosis
(Duration) N yrs. mos. ds.

(Signed) C W Shaft M. D.
Sept 15 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur de Aline — DATE OF BURIAL: Sept 1914

20. UNDERTAKER: C. J. Vassar — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St. Joseph Hospital St.)

File No.

Registered No. 12

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bert Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 27 (Day) 1872 (Year)

7. AGE: 42 yrs. 1 mos. 23 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kan

10. NAME OF FATHER: W H anderson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Levina Brown

13. BIRTHPLACE OF MOTHER (State or Country): Kan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lottie P Anderson
(Address) Mohler Idaho

15.
Filed Oct 10- 1914 L Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1914 to Sept 20 1914 that I last saw h[im] alive on Sept 20 1914 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Addisons Disease

(Duration) 5 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward Braddock M. D.

Sept 21 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rosalia Wash — DATE OF BURIAL: Sept 24 1914

20. UNDERTAKER: W B Williamson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Cor. Indiana & 8th St.)

File No.
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Moore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Not known (Month) (Day) (Year)

7. AGE: 67 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry business or establishment in which employed (or employer): Lodging House

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susan E Bruce
(Address)

15.
Filed Oct 10 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 2 (Month) (Day) 20 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1914, to Aug 1st 1914 that I last saw him alive on Sept 1 19 1914 and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Cardiac Dilatation due to Arterio Sclerosis
Complication Diabetis mellitus
(Duration) Not known yrs. mos. ds.
Contributory (Secondary)
(Duration) 6 yrs. mos. ds.
(Signed) Susan E Bruce M. D.
Sept 2nd 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: Sept 2, 1914

20. UNDERTAKER: C J Vassar
ADDRESS: Lewiston

SIGN RESERVED FOR BINDING

Every item of information should be carefully supplied. AGE should be stated EXACTLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph's Hospital St.)

File No.
Registered No. 14
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME T. B. Murphy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ——— (Month) 1 (Day) ——— (Year)

7. AGE: 45 yrs. ——— mos. ——— ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Trunch
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): NY

10. NAME OF FATHER: I don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chief of Police Rice
(Address) Lewiston

15.
Filed Oct. 10 1914 L. A. Watkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25th 1914, to Sept 25th 1914, that I last saw him alive on Sept 25th 1914, and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Accident Fracture base
Skull, Fracture Left Inferior Maxillary
Inferior Maxillary
(Duration) ——— yrs. ——— mos. ——— ds.

Contributory (Secondary)
(Duration) ——— yrs. ——— mos. ——— ds.

(Signed) L. Corson M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 9/28 1914

20. UNDERTAKER: L. Carson — ADDRESS: Lewiston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston (No. 333, 6th St.)

File No.

Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H W Kinbrough

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1914 (Year)

7. AGE: 66 yrs. 6 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry business, or dstablishment in which employed (or employer): school house

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Thomas Kinbrough

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Rebekah Russell

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella Kinbrough
(Address) 333 6th St. Lewiston Idaho

15. Filed Oct. 10- 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1914, to date 191, that I last saw h[illegible] alive on Sept 17 1914, and that death occurred on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:
Found dead in bed
Probable cause Mitral regurgitation

(Duration) One yrs. mos. ds.

Contributory (Secondary) —

(Duration) yrs. mos. ds.

(Signed) J. N. Bowers M. D.

19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. DATE OF BURIAL: 9/28 1914

20. UNDERTAKER: [illegible] ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9c
Primary Registration District No. 1609
File No.
Registered No. 16

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME L. T. Monroe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. (Month) Dec (Day) 9 (Year) 56

7. AGE: 57 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: R. B. Monroe

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary Sutton

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emma L. Monroe
(Address) Orofino Ida.

15. Filed Oct 10- 1914 L. J. Berkins Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1914, to Sept 29 1914, that I last saw him alive on Sept 29 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Injury to R. Thorax
Five comp. fractures of ribs
with Pneumothorax.
(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Elmer G. Braddock M. D.
Sept 29 1914 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Orofino
Former or usual residence Orofino Ida.

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 9/30 1914

20. UNDERTAKER: J. Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. .....
Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Richard Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Oct. (Month) 18th (Day) 1833 (Year)

7. AGE: 80 yrs. 11 mos. 00 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock raiser
(b) General nature of industry business or establishment in which employed (or employer): and Farmer

9. BIRTHPLACE (State or Country): Louisville Kentucky

10. NAME OF FATHER: John Smith

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Susan Harris

13. BIRTHPLACE OF MOTHER (State or Country): — — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Smith
(Address) Caldwell c/o Jim Ford

15.
Filed 9-19-1914
John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 23 1914 to Sept. 18 1914
that I last saw him alive on Sept. 15 1914
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Paralysis

..... (Duration) ..... yrs. ..... mos. 26 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Hurry M. D.
9-20 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cemetery
DATE OF BURIAL: Sept 20 1914

20. UNDERTAKER: Peckham Co. Co.
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell.

Registration District No. 3

Primary Registration District No. 1005

(No. ..... St.)

File No. .....

Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edmund C Spencer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.: April (Month) 18 (Day) 1851 (Year)

7. AGE: 63 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Moses Spencer.

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Maria Bissel.

13. BIRTHPLACE OF MOTHER (State or Country): Vermont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emilie B Spencer

(Address) Caldwell Ida

15. Filed Sept. 24th 1914

John J. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1914, to Sept 22 1914, that I last saw him alive on Sept 22 1914, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

"Malignant"

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. 30 ds.

(Signed) J. D. Farrer M. D.

Sept 24th 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Sept 27 1914

20. UNDERTAKER: W. C. Dyer — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 62

Registration District No. 3

Primary Registration District No. 1005

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

(No. 823, Dearborn St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarissa Wheeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 23 (Day) 1836 (Year)

7. AGE: 77 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed Wheeler

(Address) Caldwell Idaho

15. Filed Oct. 9 1914

John S. Irwin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1914, to Oct 7 1914, that I last saw h-r alive on Oct 3 1914 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Influenza

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Old age & Arteriosclerosis

..... (Duration ..... yrs. ..... mos. ..... ds.

10/9 19 14 (Signed) J. Irwin M. D.

(Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shipped to Grand Meadow Minnesota

DATE OF BURIAL ..... 191...

20. UNDERTAKER: W O Dyer

ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24858

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 8915

Name Clarassa Wheeler

Date of Death 10-7-14

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) W M Cole M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. 1214 Everett St.)

File No.

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Y McNair

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov 10th (Month) (Day) 1831 (Year)

7. AGE: 82 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Ward McNair

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Katherine Haines

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D.R. McNair
(Address) Caldwell

15. Filed Oct. 9 1914 — Jos. S. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1914, to Oct. 8 1914, that I last saw h. alive on Oct. 9 1914, and that death occured on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows:
Acute nephritis -
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Jos. S. Meyer M. D.
10/9/1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 10/10 1914

20. UNDERTAKER: W.C. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 20
County of Madison Primary Registration District No. 2012 File No.
City of Victor (No. , St.) Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Howard Jacobs

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Single

6. DATE OF BIRTH: Sept. (Month) 18 (Day) 1914 (Year)

7. AGE: ...yrs. ...mos. ...ds. IF LESS than 1 day how many ... 2 hrs. or ... 30 min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Hiram Wallace Jacobs

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary C. Patterson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Jacobs
(Address) Victor Idaho.

15. Filed Sept. 21 1914 Robt. W. King Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ...191..., to ...191... that I last saw h...alive on ...191..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:
Cause of death unknown as there was no physician in attendance & body was buried without certificate.

(Duration) ...yrs. ...mos. ...ds.

Contributory (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) ...M. D.

...19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Victor Cemetery — DATE OF BURIAL: Sept. 19 1914

20. UNDERTAKER: H. W. Jacobs — ADDRESS: Victor, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Parma
(No. ....., ... St.)
Registration District No. 9
Primary Registration District No. 2007
File No. 78
Registered No. 8918
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Cockerline

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. ~~SINGLE, MARRIED~~, WIDOWED OR DIVORCED. (Write the word.): widower
6. DATE OF BIRTH. March (Month) 20 (Day) 1832 (Year)
7. AGE: 82 Yrs. 6 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: John Cockerline
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Mary Jackson
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Kinnaird
(Address) Parma Idd
15. Filed Sep 25 1914 Lulu Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 24 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 15 1914, to Sept 24 1914, that I last saw him alive on Sept 24 1914, and that death occured on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Bronchio — pneumonia
(Duration) — Yrs. — mos. 11 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. B. Alley M. D.
9-25 1914. (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Sheldon Idd — DATE OF BURIAL: Sept 27 1914
20. UNDERTAKER: Peckham Coal Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No.
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of St Jos Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

2. FULL NAME E. M. Graves

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Widowed (write the word)

6. DATE OF BIRTH March 13 1869
(Month) (Day) (Year)

7. AGE 44 yrs. ... mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Loading Lumber
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER C. M. Graves

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Mary J. Finn

13. BIRTHPLACE OF MOTHER (State or Country) New Orleans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) L. B. Graver Coeur, Idaho

15. Filed Sept 14 1914 W. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 12 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1914, to Sept 12 1914 that I last saw h[illegible] alive on Sept 12 1914 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Epilepsy

..... (Duration) ..... yrs. ..... mos. 1/2 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Leete M. D.
Sept 12 1914 (Address) St Joe Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Coeur d Alene | DATE OF BURIAL Sept 14 1914

20. UNDERTAKER W. L. Mulcahy | ADDRESS W. Mains Idaho.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Joe

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor Smith.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 17th (Day) 1914 (Year)

7. AGE: ..... yrs. 4 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo Smith.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Rose Knopp

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Smith
(Address) St Joe Idaho

15.
Filed Sept 18 1914 W. F. Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 17th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1914, to Sept 17 1914
that I last saw h in alive on Sept 13 1914
and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:
Malnutrition

..... (Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Leete M. D.
Sept 18 1914 (Address) St Joe Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho
DATE OF BURIAL: Sept 18 1914

20. UNDERTAKER: Henry Mulcahy
ADDRESS: St Maries Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. R. D. Hopkins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 14 (Day) 1894 (Year)

7. AGE: 20 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nash

10. NAME OF FATHER: Wm. L. Lewis

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Addie Orr

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. D. Hopkins
(Address) Wallace Ida

15. Filed Sept 21 1914 H. L. Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
X Sept 17 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h...alive on ..... 191...,
and that death occured on the date stated above, X at 12 P M.

The CAUSE OF DEATH* was as follows:
X Suicide by gun shot wound

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

X (Signed) Fred G Dashiell Justice Peace M. D.
9/21 1914 (Address) Herrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hinlock, Nash. | DATE OF BURIAL ..... 191...

20. UNDERTAKER: H. L. Mulcahy | ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 974
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Hayden
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. L. E. Grant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. (Month) (Day) 1846 (Year)

7. AGE: 68 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Wm Hunt

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Miss Oakley

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. M. Grant
(Address) St. Joe, Idaho

15. Filed Sept. 21 1914 W. F. Mulcahy Local Registrar

SYMS - YORK CO. PTTRS. & STNS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914, to Sept 21 1914, that I last saw h[illegible] alive on ..... 191[illegible], and that death occured on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) Yrs. 6 mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Wm Lee Lete M. D.
Sept 21, 1914 (Address) St Joe Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cemetery — DATE OF BURIAL ..... 191[illegible]

20. UNDERTAKER: H. L. Mulcahy — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of near Santa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Shallermann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single no

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE about 25 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Worked in logging
(b) General nature of industry, business, or establishment in which employed (or employer)..... Camp.

9. BIRTHPLACE (State or Country) Idaho no.

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. L. Mulcahy
(Address) St. Maries

15. Filed Sept 24 1914 W. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Sept. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 1.30 P.M.
The CAUSE OF DEATH* was as follows:
Struck by tree in woods during wind storm.
Neck broken.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Shepherd M. D.
9/21 1914 (Address) Emerald Creek

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL QR REMOVAL: St Maries — DATE OF BURIAL: Sept 24 1914

20. UNDERTAKER: H. L. Mulcahy — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 8926
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of St. Joe

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Winfield Scott Greeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): marri[illegible]

6. DATE OF BIRTH. Aug. 30 eh - 1876 (Month) (Day) (Year)

7. AGE: 38 Yrs. 29 Mos. days ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: passenger conductor
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Van Wert Ohio

10. NAME OF FATHER: E. D. Greeley

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Laura Melechiemer

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Miss Jessie Greeley
(Address): Seattle - 11 - Metropolitan

15. Filed 8/11 30 1914 H. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8/11 (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191...,
that I last saw h[illegible] alive on ..... 191...,
and that death occured on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
Hardening of the arteries
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
29 1914 (Address) Kootenai County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nebraska City Iowa
DATE OF BURIAL ..... 191...
20. UNDERTAKER: H. L. Mulcahy
ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

OVID - YORK CORP'TN. 6 CONN. 24055

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [illegible]
Registered No. 392

1. PLACE OF DEATH.
County of Washington
City of Midvale

Registration District No. 87
Primary Registration District No. 2154
(No. 20 miles east of Midvale St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phillipp Phiffer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: May (Month) – 16 (Day) – 1869 (Year)
7. AGE: 44 yrs. 9 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): "
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (State or Country): "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ina Phiffer
(Address) Westfall Oregon
15.
Filed March 25 1914 Hamilton E Snyder Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) – 25 (Day) – 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1914., to — 191..
that I last saw h[illegible] alive on — 191..
and that death occurred on the date stated above, at 4:30 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Acute Dilatation of Heart
(Duration) — yrs. ..... mos. 1 ds.
(Signed) W. A. Marshall M. D.
Feb 27 1914 (Address) Midvale, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westfall Oregon — DATE OF BURIAL: March 1 1914
20. UNDERTAKER: R. W. Bowen. — ADDRESS: Weiser, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 592
Registered No. 44

1. PLACE OF DEATH.
County of Washington
City of Weiser, Idaho (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 2112

2. FULL NAME Dallie Wells.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 4 (Day) 1906 (Year)

7. AGE: 8 yrs. 3 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington Co, Idaho

10. NAME OF FATHER: Dudley Wells.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Pearl Hindman

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Hindman
(Address) Weiser, Idaho

15. Filed 10-3 1914 W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1914, to Oct 3 1914
that I last saw her alive on Oct 2 1914
and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:

Diabetis

(Duration) ..... yrs. 6 mos. ..... ds.
Contributory (Secondary) Diabetis Coma
(Duration) ..... yrs. 1 mos. 3 ds.
(Signed) Ernest O. Fenn M. D.
Oct 3 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery
DATE OF BURIAL: 10/4/14 1914

20. UNDERTAKER: W. M. Bratney
ADDRESS: Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. ....., ... St.)

File No. .....
Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pondexter P. Dawson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 25 (Day) 1840 (Year)

7. AGE: 74 yrs. 2 mos. 6 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Hiram Dawson

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Sallie Fosturn

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susanna M. Dawson
(Address) Weiser Idaho

15.
Filed Oct. 1 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1914, to Oct. 1, 1914
that I last saw h-- alive on Sept 29 1914
and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Endocarditis, with Mitral Insufficiency

(Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary) Senility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest O. Finney M. D.
Oct 3 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Oct 2 1914

20. UNDERTAKER: L. C. Northam — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. West Commercial St.)

File No.
Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David H. Whitmore, Jr.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May — — 1897 (Month) (Day) (Year)

7. AGE: 17 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of Utah

10. NAME OF FATHER: David H. Whitmore

11. BIRTHPLACE OF FATHER (State or Country): State Virginia

12. MAIDEN NAME OF MOTHER: Pearl L. Myers

13. BIRTHPLACE OF MOTHER (State or Country): State of Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David H. Whitmore
(Address) Weiser, Idaho

15.
Filed Sept. 29 1914 W. R. Hamilton E.S. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. — 29 — 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1. 1914, to Sept 28 1914 that I last saw him alive on Sept 28 1914 and that death occurred on the date stated above, at 6 45 A.M.

The CAUSE OF DEATH* was as follows:
Typhoid fever.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James Ayers M. D.
Sept 30. 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser, Idaho
DATE OF BURIAL: Sept 30 1914

20. UNDERTAKER: R. W. Bowen
ADDRESS: Weiser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. ....., ... St.)

File No. .....
Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry W. Shannon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March – 7 – 1873
(Month) (Day) (Year)

7. AGE: 41 yrs. 4 mos. 23 ds.
IF LESS than how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Beaver City Utah

10. NAME OF FATHER: Thomas Shannon

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Agnes Busbee

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Shannon
(Address) Weiser Ida

15.
Filed 8-7 1914 W R Hamilton E. S. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August – 6 – 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from – 191..., to – 191...
that I last saw h– alive on – 191...
and that death occurred on the date stated above, at 12 50 P.M.

The CAUSE OF DEATH* was as follows:
apoplexy.
immediate.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frances E. Cameron M. D.
Aug 11 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser, Idaho
DATE OF BURIAL: 8/8 1914

20. UNDERTAKER: R. M. Brown
ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. ....., ... St.)

File No. .....
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jonathan Hemenway

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: May (Month) 6 (Day) 1 (Year)

7. AGE: 82 yrs. 2 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): State of Vermont

10. NAME OF FATHER: Gardner Hemenway

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Tillison

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Hemenway
(Address) Weiser, Ida.

15.
Filed Aug 3 1914 W. R. Hamilton E.S. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914, to Aug 2 1914
that I last saw him alive on Aug 2 1914
and that death occurred on the date stated above, at 8.30 A.M.
The CAUSE OF DEATH* was as follows:
Apoplexy
16 hrs
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Chiles M. D.
8/3 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser, Idaho
DATE OF BURIAL: 8/4 1914

20. UNDERTAKER: R. V. Bowen
ADDRESS: Weiser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Willard Eaton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 29 (Day) 1914 (Year)

7. AGE — Yrs. 3 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Okla.

10. NAME OF FATHER: Elmer Willard Eaton

11. BIRTHPLACE OF FATHER (State or Country): Okla.

12. MAIDEN NAME OF MOTHER: Nora Ethel Miller

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bessie Lenora Love

(Address) Burley

15.

Filed Sept. 11th 1914

Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. (Month) 11th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10th 1914, to Sept. 11th 1914, that I last saw him alive on Sept. 10th 1914, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Malnutrition

.....(Duration) ..... Yrs. 3 mos. 13 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

9-11 1914 (Address) Burley, 2 da.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cem. DATE OF BURIAL 191

20. UNDERTAKER: A. L. Watt ADDRESS: Burley

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8935
Registered No.

1. PLACE OF DEATH.
County of Bonner
City of Priest River
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs. Hazel Judge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1914 (Year)

7. AGE: 22 yrs. 6 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Harry le Robinson

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Jennie Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chas Judge
(Address): Priest River Ida

15. Filed Sept. 10 1914 E. V. McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1914., to Sept 9 1914 that I last saw h[illegible] alive on Sept 9 1914, and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Trouble
Chronic Myocardial Insufficiency.

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Howard le Chisle M. D.
Sept 10 1914 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River
DATE OF BURIAL: Sept 10 1914

20. UNDERTAKER [redacted] Mone
ADDRESS: Priest River

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8937

Registered No. 38

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2045

County of Bannock

City of Inkom Springs (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Joseph Hager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH: Aug (Month) 29 (Day) 1848 (Year)

7. AGE: 66 yrs. 1 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Situsville Pa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Carrie A. Patton

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burt Hager
(Address) Dempsey Idaho

15. Filed Oct 10, 1914 Ellis Kaucy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sep. (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1914, to Sep 30, 1914, that I last saw h[illegible] alive on Sep 30, 1914, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Senile Gangrene

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebral Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Kaucy M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Beaver Dale — DATE OF BURIAL: .....191..

20. UNDERTAKER: Tony Russell — ADDRESS: Pocatello, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Perry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2047
(No. ____ St.)

File No. ____
Registered No. 39
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Tanner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
W	W	Single

6. DATE OF BIRTH: May (Month) 26 (Day) 1914 (Year)

7. AGE: ____ yrs. ____ mos. 12 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Perry, Idaho

10. NAME OF FATHER: John L. Tanner

11. BIRTHPLACE OF FATHER (State or Country): Ut

12. MAIDEN NAME OF MOTHER: Lyle Warren

13. BIRTHPLACE OF MOTHER (State or Country): Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Tanner
(Address) Perry, Idaho

15. Filed Oct 10, 1914 Ellis Bowers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Ne attended 191__, to ~ 191__
that I last saw h~ alive on ~ 191__
and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ~

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Ellis Bowers M. D.
Oct 10 1914 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs ____ mos ____ ds. In the State ____ yrs ____ mos ____ ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mineral Valley — DATE OF BURIAL: Sept 8, 1914

20. UNDERTAKER: None — ADDRESS: ~

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Central
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048
(No. ..... St.)

File No.
Registered No. 40
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Christian Swenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ~~Sept.~~ Feb. (Month) ~~19~~ 18 (Day) ~~1844~~ 1844 (Year)

7. AGE: 70 yrs. 7 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Christ Swenson

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dorothea Kruse

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred Swenson (Son)
(Address): Central

15. Filed Oct 14, 1914 Eric Kaag, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1914, to Sep 28 1914
that I last saw h[illegible] alive on Sep 1, 1914,
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease
(Duration) 1 yrs. — mos. — ds.
Contributory (Secondary) ——
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Eric Kaag M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Central Id — DATE OF BURIAL: Sep 30 1914

20. UNDERTAKER: Ed Wheelis — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25, M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

File No. ____

County of Bannock

City of Soda Springs (No. ____, ____ St.)

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Doty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 6th 1868 (Month) (Day) (Year)

7. AGE: 46 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: C. D. Doty

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Hannah Childs

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Doty
(Address) Midvale Utah

15. Filed Oct 10, 1914 Edis Kasey, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 9th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1914, to Oct 9th 1914, that I last saw him alive on Oct 9 1914, and that death occured on the date stated above, at 2:45 M.

The CAUSE OF DEATH* was as follows:
Phthysis Pulmonus

(Duration) ____ Yrs. 6 mos. ____ ds.

Contributory (Secondary): None

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) Edis N Casey M. D.

Oct 10 1914 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Salt Lake — DATE OF BURIAL: Oct 13 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PYRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2200
File No. 3941
Registered No. 21

1. PLACE OF DEATH.
County of Shoshone
City of Burke
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick Hagerty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 30 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Gillespie
(Address) Burke Idaho

15. Filed 9/12 1914 W. F. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h[illegible] alive on ..... 191...,
and that death occured on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows:
A gunshot wound of
Chest.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. F. Mowry M. D.
9/8 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Ward Undertaking Co
ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No.

1. PLACE OF DEATH.
County of Latah
City of (No. , St.)
Registration District No. 65
Primary Registration District No. 2145

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kathline Vorell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: March – 1912 (Month) (Day) (Year)

7. AGE: 2 yrs. 7 mos. – ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Latah Co. Ido

10. NAME OF FATHER: Fred Vorell

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Wilcox. Edna

13. BIRTHPLACE OF MOTHER (State or Country): Ido.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Vorell
(Address) Palouse Wn.

15. Filed Oct. 3 1914 D. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 3 (Day) 9 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental shooting caused by order of coroner.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
..... (Duration) – yrs. – mos. ..... ds.
(Signed) E A Stein M. D.
10. 3 1914 (Address) 203 Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash
DATE OF BURIAL: Oct 4 1914
20. UNDERTAKER: E Anderson
ADDRESS: Palouse Wash

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-2
(No. ....., ... St.)

File No. 895
Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Marshal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 16 (Day) 1914 (Year)

7. AGE: ..... Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Michael Marshal

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Gertrude Lumburg

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Michael Marshal
(Address) Idaho Falls

15. Filed Sept 30 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw him alive on Sept 29 1914
and that death occured on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Don't Know -
Probably malnutrition
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
9/29 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Sept 30 1914

20. UNDERTAKER: G H Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTTG. & BKBG. 24622

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8945

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2130

(No. ..... Capital Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kate D Martindale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. April 11 1865 (Month) (Day) (Year)

7. AGE: 49 Yrs. 5 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Saml. Dexter Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Rumford, Maine

12. MAIDEN NAME OF MOTHER: Sarah J Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Barnet, Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Dickman, Jr.

(Address)

15. Filed Aug 19 1914 C C Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 10 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25th 1914, to Sept 10 1914, that I last saw her alive on Sept 9th 1914, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Tong Tablet (Morphine)

Drug Habit, Several yrs.
(Duration) Yrs. mos. ds.

Contributory (Secondary): None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Mayes M. D.

9/19 1914 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rest Haven Cem | DATE OF BURIAL: Sept 13 1914

20. UNDERTAKER: C C Dinwoodey | ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73
Primary Registration District No. 2150
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 7

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Malcum A Greholver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Child

6. DATE OF BIRTH. Aug. (Month) 28 (Day) 1914 (Year)

7. AGE: + Yrs. X Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: J. D. Greholver

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Alvira Gibson

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. D. Greholver
(Address) Idaho Falls, Ida.

15. Filed 9/9 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suffocation
Accidental
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) (no Doctor) M. D.
9/9 19... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Sweden — DATE OF BURIAL: 9/9 1914

20. UNDERTAKER: C. C. Dimmoody — ADDRESS: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls.

Registration District No. 73

Primary Registration District No. 2150

(No. ....., ... St.)

File No. .....

Registered No. 19a

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie Stewart

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 18 (Day) 1914 (Year)

7. AGE ..... Yrs. 2 Mos. — ds.

IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Spokane Wash

10. NAME OF FATHER John L Stewart

11. BIRTHPLACE OF FATHER (State or Country) Ogden Utah

12. MAIDEN NAME OF MOTHER Nellie Yaryan

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L Stewart

(Address) Idaho Falls Ida

15.

Filed Sept 18 1914

J E Emmett
Dep. Local Registrar

SYMS - YORK CO. PTRS. & ENGS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to — 191...,

that I last saw h— alive on — 191...,

and that death occured on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

Probable Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) G. R. Sadmyer M. D.

9/18 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Rose Hill — DATE OF BURIAL Sept 18 1914

20. UNDERTAKER J H Hunt — ADDRESS Idaho Falls

FORM V. S. No. 6-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8948

Registered No. 1

Registration District No. 73

Primary Registration District No. 2150

1. PLACE OF DEATH.

County Bonneville

City or Idaho Falls (No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Stapleton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov. (Month) 7 (Day) 1866 (Year)

7. AGE: 47 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert Stapleton Per Kinnaird
(Address) Idaho Falls, Ida Irwin

15. Filed Oct 1 1914 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BSRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1914, to Sept 28, 1914, that I last saw h~~im~~ alive on Sept. 28. 1914, and that death occured on the date stated above, at 4:9 M.

The CAUSE OF DEATH* was as follows:
Carcinoma uteri.
Indefinite (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John O'Mellon M. D.
10/1 1914 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver, Colo — DATE OF BURIAL: ——— 1914

20. UNDERTAKER: C. C. Kinnaird — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 21-0

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Williams Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 15 (Day) 1914 (Year)

7. AGE: ..... Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph Williams

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Viola Smith

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Williams

(Address) Idaho Falls

15.

Filed ..... 191.. .....

Local Registrar

SYMS - YORK CO., PTRS. & BKRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1914, to Sept. 1914, that I last saw h[illegible] alive on Sept 26 1914, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) ..... Yrs. ..... mos. 4 d ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

9/4 19.. (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Idaho — DATE OF BURIAL: Sept 28 191..

20. UNDERTAKER: G F Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12

County of Kootenai Primary Registration District No. 2057

City of Mica Athol (No. ....., ... St.)

File No. 2

Registered No. 481

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jasper Newton Douglas

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: July (Month) 22 (Day) 1846 (Year)

7. AGE: 68 yrs. 2 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James Douglas

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Emaily Vaughn

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. Ramoes
(Address) Cheney, Wash

15. Filed Oct 10 1914 D. D. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h..... alive on ....., 191...,
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Suddenly died
Had no Doctor.
Supposed Heart disease

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Freeman M. D.

9/24 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Athol Ida — DATE OF BURIAL: Sept 25 1914

20. UNDERTAKER: C. K. Kopp — ADDRESS: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2017
File No.
Registered No. 430

1. PLACE OF DEATH.
County of Kootenai
City of Spirit Lake
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. A. LaCroix

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Supposed Single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE about 25 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Apparent Lumberjack
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Kadish
(Address) Spirit Lake

15.
Filed 10/10 191[illegible] A. R. Bowman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept. (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 191[illegible], to [illegible] 191[illegible], that I last saw h[illegible] alive on [illegible] 191[illegible], and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Gun Shot wound
Murder
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. B. Shepard M. D.
19 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spirit Lake	Sept 30 1914

20. UNDERTAKER M. Kloppe ADDRESS Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 12760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 14
Primary Registration District No. 2051
(No. ....., ... St.)

File No. .....
Registered No. 428
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME N. F. Moran

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: 4 (Month) ..... 1 (Day) ..... (Year)

7. AGE: 76 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Kephartin
(Address) C D A

15. Filed Oct 10 1914 S. D. Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 19 1914, to Sept. 1 — 1914, that I last saw h..... alive on 9 / 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of the Face

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. D. Brennan M. D.

9/12 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls. DATE OF BURIAL: 1914

20. UNDERTAKER: C C Bobo ADDRESS: Rens

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1st
Primary Registration District No. 2051
(No. ..... , ... St.)

File No. .....
Registered No. 427
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George McCleary

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	Caucasian	S

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
40 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Day Labor
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Texas

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George McCleary
(Address) Heaven

15.
Filed Oct 10 1914 J D Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug. (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 191.., to Aug 30 1914
that I last saw h..... alive on Aug 30 1914
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Brennan M. D.
8/31 1914 (Address) J D Brennan Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Constant. ..... yrs. ..... mos. ..... days.
In the State Rathdrum ..... yrs. 1 ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rathdrum | DATE OF BURIAL ..... 191..

20. UNDERTAKER J R Hoyt Rathdrum | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Spirit Lake

Registration District No. 12
Primary Registration District No. 2057
(No. ....., ... St.)

File No. .....
Registered No. 406

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pete Larson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Do not know (Month) (Day) 1 (Year)

7. AGE: about 31 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer in
(b) General nature of industry business or establishment in which employed (or employer): Timber Camp

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Aug 10 1914 — D. D. Brennan, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1914, to Aug 7th 1914
that I last saw him alive on Aug 6th 1914
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia Complicated with tuberculosis
..... (Duration) ..... yrs. ..... mos. 6 ..... ds.
Contributory (Secondary) Pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Earle P Brindle M. D.
Aug 7 1914 (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 ds. In the State Ida. yrs. ..... mos. ..... ds.
Where was disease contracted, If not at place of death? In timber camp 5 mi. away
Former or usual residence Millers Mountain

19. PLACE OF BURIAL OR REMOVAL: Spirit Lake — DATE OF BURIAL: Aug 9 1914

20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
...m of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
...ould state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
... OF OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of McCall
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2981
(No. ....., ... St.)

File No. .....
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evan Minor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Sept 1, 1914 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
..... (Month) ..... (Day) 191.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Struck by lightning

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
Aug 1 1914 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
McCall Idaho	191....
20. UNDERTAKER	ADDRESS
None (Impossible to obtain)	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Harpster
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 34
Registered No. 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elmer G. Rupe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	

6. DATE OF BIRTH: July (Month) 11 (Day) 1914 (Year)

7. AGE: 0 yrs. 2 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Harpster Ida

10. NAME OF FATHER Lloyd Rupe

11. BIRTHPLACE OF FATHER (State or Country) Livingston Co Mo

12. MAIDEN NAME OF MOTHER Mabel Shearer

13. BIRTHPLACE OF MOTHER (State or Country) Grangeville, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. G. Rupe
(Address) Harpster. Idaho.

15.
Filed Oct 6 1914 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Found dead in bed.
Baby nursed one hour before
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Warren M. D.
9-15-1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....,mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harpster Ida, | DATE OF BURIAL: Sept 16 1914

20. UNDERTAKER: None | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. # 1007
City of Blackfoot (No. 147, Maple No 4 St.)
File No.
Registered No. 51
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lorta Joyce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Jany (Month) 29 (Day) 1914 (Year)
7. AGE: yrs. 7 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Blkfoot Ida
10. NAME OF FATHER: Andy Joyce
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Anna Carder
13. BIRTHPLACE OF MOTHER (State or Country): Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Davis MD
(Address) Blackfoot Ida
15. Filed Sept. 2 1914 M E Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 2 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1914, to Sept 2 1914
that I last saw h— alive on Sept 2 1914
and that death occurred on the date stated above, at 6.50 A M.
The CAUSE OF DEATH* was as follows:
Gastro Enteritis
(Duration) — yrs. — mos. — ds.
Contributory (Secondary) —
(Duration) yrs. mos. ds.
(Signed) J B Davis M. D.
9-2-14 19 (Address) Blkfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cem. Blackfoot — DATE OF BURIAL: Sept 2 1914
20. UNDERTAKER: S J Knox — ADDRESS: Bfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 421

Primary Registration District No. 1007

County of Bingham

City of Blackfoot

(No. 116 South Fuller Ave, St.)

File No. .....

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Jane Bond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 21 (Day) 1883 (Year)

7. AGE: 31 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Wm. A Sample

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Sabray E. Mollenkopf

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Fisher

(Address) Blackfoot Idaho

15. Filed Sept 5th 1914 W. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Drowning in Snake River

Excise Accident or Intentional

Verdict of Coroners Jury.

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) E J Peck Coroner M. D.

.....19..... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fern Hill Cemetery — DATE OF BURIAL: Sept 6 1914

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2 94
(No. .... St.)

File No. .....
Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of Bronnaca

2. FULL NAME Marvin Stander

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. September 7th 1914
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.? Two

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Thomas Idaho

10. NAME OF FATHER John H Stander

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Katherin Adams

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John H Stander
(Address) Blackfoot Idaho R.F.D 2.

15.
Filed Sept 8 1914 M E Tabis
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 7th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1914, to Sept 7 1914, that I last saw him alive on Sept 7 1914, and that death occured on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:
Direct Cause not known
Was an instrument
delivery
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) About one month premature
(Duration — yrs. — mos. — ds.
(Signed) W W Beck M. D.
9/8 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pocatello — DATE OF BURIAL Sept 8 1914

20. UNDERTAKER John H Stander — ADDRESS Blackfoot.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1007
(No. ....., ... St.)

File No. .....
Registered No. 54
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lora Thatcher Baldwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1914 (Year)

7. AGE: ..... yrs. 11 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ——
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) California

10. NAME OF FATHER Lora Baldwin

11. BIRTHPLACE OF FATHER (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Sabra A. Moore

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lora. Baldwin.
(Address) Blackfoot Ida

15. Filed Sept 13 1914 M E Price Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1914, to Sept 12 1914, that I last saw him alive on Sept 12 1914, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) — yrs. — mos. 5 ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) J. L. Condit M. D.

9/12 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose City Cem — DATE OF BURIAL: Sept 14 1914

20. UNDERTAKER: Lora Baldwin. — ADDRESS: Blackfoot Route 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 1007

City of Blackfoot (No. Bippell Add. St.)

File No. 5903

Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hannah Isabelia Dawson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: January (Month) 16 (Day) 1829 (Year)

7. AGE: 85 yrs. 8 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Jacob Scott

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Keller

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence William Dawson
(Address) Sweet Sage

15. Filed Sept. 22 1914 M. E. Lakie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 20th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1914, to Sept 20 1914, that I last saw h.. alive on Sept 19 1914, and that death occurred on the date stated above, at 1P M.

The CAUSE OF DEATH* was as follows:

Medical Regurgitation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Summers M. D.

9/21/1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery | DATE OF BURIAL: Sept 22 1914

20. UNDERTAKER: E. J. Peck | ADDRESS: Blackfoot Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 56

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. Idaho Jeanne Boydston St.)

Registration District No. 121

Primary Registration District No. 219K

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myra Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 54 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Alabama

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Boyd

(Address) Blackfoot Idaho

15. Filed Sept. 22 1914 M. E. Fabin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 19th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1914, to Sept 19th 1914, that I last saw h alive on Sept 19th 1914, and that death occured on the date stated above, at 8-0 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Dont Know (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Dont Know

..... (Duration — yrs. ..... mos. ..... ds.

(Signed) Geo. Boyd M. D.

Sept 22 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs. 2 mos. 23 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Boise —

Former or usual residence Boise —

19. PLACE OF BURIAL OR REMOVAL: Fairview Cemetery — DATE OF BURIAL: Sept 22 1914

20. UNDERTAKER: E J Funk — ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. PTRS. & BORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121

County of Bingham Primary Registration District No. 2194

~~City of~~ Kimball Ward No. ....., ... St.)

File No. .....

Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Jorgensen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 27 (Day) 1914 (Year)

7. AGE: ..... yrs. 6 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kimball Idaho

10. NAME OF FATHER: John Peter Jorgensen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rosie Nielson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Jorgensen
(Address) .....

15. Filed Sept 21 1914 M E Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 21 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ saw him alive on 191 , to 191 , ~~that I last saw him alive on 191~~ , and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M E Patrie Registrar M. D.

Sept 21 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basalt Cemetery — DATE OF BURIAL: Sept 22 191 4

20. UNDERTAKER: J. P. Jorgensen — ADDRESS: Blackfoot Route 3

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Moreland Prec (No. ....., ... St.)
File No. 8966
Registered No. 59
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Wilkins Manwaring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 11 (Day) 1859 (Year)

7. AGE: 54 yrs. 11 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: ? Wilkins

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) (Son) X Orson Manwaring
(Address) Blackfoot Route 4

15. Filed Sept 26 1914 M E Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Sorrowfully last ~~saw her alive~~ death
191..., to ...191...,
~~that I last saw her alive~~ on ...191...,
and that death occurred on the date stated above, at 6.50 P. M.

The CAUSE OF DEATH* was as follows:
Mural Debility
.....
.....
(Duration) 10 yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia Hypostatica
(Duration) 10 yrs. ..... mos. ..... ds.
(Signed) M E Patrie M. D.
9/26 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moreland Cem. DATE OF BURIAL: Sept. 28 1914

20. UNDERTAKER: Orson Manwaring ADDRESS: Route 1

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot Ida
(No. R. F. D. No 1, St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194

File No.
Registered No. 60
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Francis Britanna Black

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH: 9 (Month) 29 (Day) 1914 (Year)
7. AGE: yrs. 8 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): None
9. BIRTHPLACE (State or Country): Spanish Fork, Utah
10. NAME OF FATHER: Lorenzo D Black
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Jane May Edison
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorenzo D Black
(Address) Blackfoot Ida R. F. D. 1
15.
Filed Oct 1 1914 M. E. Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 29 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1914, to Sept 29 1914, that I last saw her alive on Sept 28 1914 and that death occurred on the date stated above, at 11.10 M.
The CAUSE OF DEATH* was as follows:
Acute Infection - General Toxemia
(Duration) ..... yrs. ..... mos. 8 ds.
Contributory (Secondary) Indigestion & Imal Assimulation
(Duration) ..... yrs. 2 mos. ..... ds.
(Signed) E A Hagan M. D.
9/30 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside cemetery — DATE OF BURIAL: Oct 1 1914
20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

County of Bingham

City of Blackfoot (No. Duffy addition St.)

File No.

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna VanBlaricom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec 10 1898 (Month) (Day) (Year)

7. AGE: 15 yrs. 8 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bonneville Co. Idaho

10. NAME OF FATHER: P B VanBlaricom

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Harriet Blanchu

13. BIRTHPLACE OF MOTHER (State or Country): Brigham City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P B VanBlaricom
(Address)

15. Filed Oct 1 1914 M. E. Pate Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th 1914, to July 7 1914, that I last saw her alive on July 7 1914 and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:
Endocarditis, mitral insufficiency,
(Duration) 2 yrs. — mos. — ds.
Contributory (Secondary) None known
(Duration) — yrs. — mos. — ds.

(Signed) C W Beck M. D.
10/1 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fem Lily Cemetery — DATE OF BURIAL: Oct 1st 1914

20. UNDERTAKER: E J Buck — ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

File No. 8969

County of Bingham

City of Blackfoot (No. 120 University St.)

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alta Louise Marvin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1894 (Year)

7. AGE: 20 yrs. 8 mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. G. Marvin

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Mary J. Watson

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura Crowley

(Address) Idaho Falls

15. Filed Oct 1 1914 W. E. Fabrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1913, to Sept 30 1914, that I last saw her alive on Sept 30 1914 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 10 yrs. — mos. — ds.

Contributory (Secondary) — (Duration) — yrs. — mos. — ds.

(Signed) F. W. Mitchell M. D.

9/30 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery — DATE OF BURIAL: Oct 3 1914

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 1007

City of Blackfoot (No. 105 North Maple St.)

File No.

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen Turner

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M.	W.	Single

6. DATE OF BIRTH Unknown 1 (Month) (Day) (Year)

7. AGE 76(?) yrs. ——— mos. ——— ds. — IF LESS than 1 day how many ..... *hrs. or* .....

8. OCCUPATION
(a) Trade, profession or particular kind of work ..Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER Nathan Turner

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Davis
(Address) Blackfoot Ida

15. Filed Oct 3rd 1914 M. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 30 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1914, to Oct 1 1914, that I last saw him alive on Sept 30 1914 and that death occurred on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

.....(Duration).....yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) J. B. Davis M. D.
Oct 1 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State ....yrs....mos....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Groundcliff Cemetery	Oct 3 1914
20. UNDERTAKER E. F. Peck	ADDRESS Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

File No. .....

County of Bingham

City of Blackfoot R.F.D #4 (No. ....., ... St.)

Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Dixon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. July (Month) 23 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Blackfoot, Idaho.

10. NAME OF FATHER Thomas Dixon

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Roane Farnsworth

13. BIRTHPLACE OF MOTHER (State or Country) Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Dixon

(Address) Blackfoot R.F.D. #4

15. Filed Aug. 1st 1914 M. Patrick Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24659

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914, to Aug 1 1914 that I last saw her alive on July 1 1914 and that death occured on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary) —

.....(Duration — yrs. — mos. — ds.

(Signed) W.W. Beck M. D.

Aug 1 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moreland (C) Ida	Aug 2 1914
20. UNDERTAKER Thomas Dixon	ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No.
Registered No. 45

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot, Ward
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margarete Anny Fackrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 19 (Day) 1913 (Year)

7. AGE: ..... Yrs. 10 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Parley Proctor Fackrell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lucy Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. P. Fackrell
(Address) .....

15. Filed Aug 5 1914 — W. E. Lakin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1914, to Aug 4 1914, that I last saw her alive on Aug 4 1914, and that death occured on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Enterocolitis

..... (Duration) — Yrs. — mos. 6 ds.

Contributory (Secondary) —

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.

Aug 5 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside-Thomas Cem — DATE OF BURIAL: Aug 6 1914

20. UNDERTAKER: J. P. Fackrell — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Insane Asylum St.)

File No.
Registered No. 47
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Miguel Castenado

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Caucasian	Single

6. DATE OF BIRTH — — 1886
(Month) (Day) (Year)

7. AGE 28 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer (Day)
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Mexico.

10. NAME OF FATHER Marcus Castenado.

11. BIRTHPLACE OF FATHER (State or Country) Juarez, Mexico

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. E. Hyde
(Address) Blackfoot Idaho

15. Filed Aug 13 1914 M. E. Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August 7th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1913, to Aug 7th 1914, that I last saw h— alive on Aug 7th 1914, and that death occurred on the date stated above, at 1-30 A.M.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

(Duration) — yrs. 2 mos. — ds.

Contributory (Secondary) Syphilis

(Duration) Don't Know yrs. mos. ds.

(Signed) Geo. E. Hyde M. D.

Aug 12 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 4 mos. 14 days. In the State 5 yrs. — mos. — days.

Where was disease contracted if not at place of death? Don't Know

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Asylum Cemetery | DATE OF BURIAL Aug 7 1914

20. UNDERTAKER Geo E Hyde ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 8975
Registered No. 48

1. PLACE OF DEATH.
County of Bingham
~~City~~ of Pattonsville
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucii Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 22 (Day) 1884 (Year)

7. AGE: 30 Yrs. 4 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home maker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Adaho Idaho

10. NAME OF FATHER: Harmon Cox

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Sarah Samson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alta B. Bruce
(Address) Blackfoot R.I.

15. Filed Aug 18 1914 M. E. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Aug 17th 1914,
that I last saw h— alive on —— 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental Gunshot wound through heart and lung
instant death
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) ——
(Duration — yrs. — mos. — ds.

(Signed) J B Davis M. D.
8/18 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Idaho — DATE OF BURIAL: Aug 19 1914

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Kimble
Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)
File No. .....
Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marlund Jorgenson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Feb (Month) 28 (Day) 1914 (Year)

7. AGE: ..... yrs. 6 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kimble

10. NAME OF FATHER: John Peter Jorgenson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rose Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Peter Jorgenson
(Address) Blackfoot R. F. D. no 3

15. Filed Aug 26 1914 W. E. .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24, 1914, to Aug 24, 1914, that I last saw him alive on Aug 24, 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Infantile Diarrea

..... (Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....
..... (Duration) — yrs. — mos. — ds.

(Signed) John B. Cooper M. D.
2 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basalt Cemetery — DATE OF BURIAL: Aug 27 1914

20. UNDERTAKER: John Peter Jorgenson — ADDRESS: Blackfoot Rt. 3,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2194
(No. ....., ... St.)

File No. .....
Registered No. 50

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Pankoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. — (Month) — (Day) 1858 (Year)

7. AGE: 56 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B Davis M D
(Address) Blackfoot Ida

15. Filed Aug 31 1914 W. E. Yates Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1914, to Aug 30 1914, that I last saw him alive on Aug 29 1914 and that death occured on the date stated above, at 5:45 A. M.

The CAUSE OF DEATH* was as follows:
Acute Dysentery

(Duration) — Yrs. — mos. 15 ds.

Contributory (Secondary) .....
(Duration — Yrs. — mos. — ds.

(Signed) B Davis M. D.
8/30 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ferm City Cemetery	Aug 31 1914
20. UNDERTAKER: E J Peck	ADDRESS: Blackfoot

SYMS - YORK CO., PTRS. & BKRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. .....
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marguerite Ebbert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. March 18th 1912 (Month) (Day) (Year)

7. AGE: 2 Yrs. 5 Mos. 16 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) Twin Falls Ida

10. NAME OF FATHER Wm D Ebbert

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Laura Berra

13. BIRTHPLACE OF MOTHER (State or Country) Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm D Ebbert
(Address) Twin Falls Ida, Sept 4 1914

15. Filed 9-4 1914 John M Coughlin Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 4th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 31 1914, to Sept. 3 1914, that I last saw h-er alive on Sept 3 1914, and that death occured on the date stated above, at 12½ A M.

The CAUSE OF DEATH* was as follows:
Cholera infantum

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Spinal meningitis
(Duration ..... yrs. ..... mos. — ds.

(Signed) H W Wilson M. D.
Sept 4 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 9/4 1914

20. UNDERTAKER: B Marsh — ADDRESS: Twin Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of ~~or~~ "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 7085
(No. ....., ... St.)

File No.
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allen Francis Gault

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH
August (Month) 13 (Day) 1852 (Year)

7. AGE
78 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) General Ranch Work

9. BIRTHPLACE (State or Country) Nebr.

10. NAME OF FATHER C. F. Gault

11. BIRTHPLACE OF FATHER (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Laura Dowling

13. BIRTHPLACE OF MOTHER (State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adelbert Gault
(Address) Twin Falls

15.
Filed Sept 5 1914 John A. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
September (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/23/1914, to 9/5/1914, that I last saw him alive on 9/4/1914 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) ..... yrs. ..... mos. 12 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Pike M. D.
9/5/1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days.
In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR ~~REMOVAL~~ Twin Idaho
DATE OF BURIAL ..... 191...

20. UNDERTAKER Church (Cooley B)
ADDRESS ~~Twin~~ Twin Falls

GYMS - YORK CO., PTRS. & SDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1083
File No.
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Hansley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. 11 1883 (Month) (Day) (Year)

7. AGE: 30 yrs. 9 mos. 28 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thos. Hansley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jessie Smith

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Curtis Quiles
(Address): Albion

15. Filed Sept 8 1914. John W. Eagleton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September 8th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7th 1914, to Sept 8 1914, that I last saw him alive on Sept 8 1914, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Cerebral Concussion X

(Duration) yrs. mos. 6 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Jos Boyd M. D.
Sept 8 1914 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion, Idaho
DATE OF BURIAL: Sept 9th 1914

20. UNDERTAKER: H. J. Evans
ADDRESS: Burial ~~Twin Falls~~ Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of 11 11
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 8983
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Allen Ray.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct. (Month) 31 (Day) 1913 (Year)

7. AGE: ..... yrs. 11 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER H. H. Ray

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Ella Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hawley H. Ray
(Address) Twin Falls

15. Filed Sept. 12 1914 John Bryden Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 11 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Sept 11 1914, that I last saw him alive on Sept. 8 1914, and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Tubercular peritonitis

(Duration) ..... yrs. [redacted] mos. [redacted] ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Worlan M. D.
Sept 11 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: Sept. 12 1914

20. UNDERTAKER: J. Donovan ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 8984
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.
(No. ... St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert J. W. Lutz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Widower

6. DATE OF BIRTH: Dec (Month) 12 (Day) 1838 (Year)

7. AGE: 76 yrs. 8 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Jeweler
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springfield Ill.

10. NAME OF FATHER: R. J. White

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Martha E Bradshaw

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E. S. Barnes
(Address): Rogerson Idaho

15.
Filed 9-17 1914
John T. Eagleton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/19/1914; to 9/15/1914, that I last saw him alive on 9/14/1914, and that death occurred on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH* was as follows:

Senile gangrene

(Duration) ... yrs. ... mos. 14 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) Several yrs. ... mos. ... ds.

(Signed) W. G. Poe M. D.

9/16 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	9/18 1914

20. UNDERTAKER: Marsh — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ....., ... St.)

File No. 3913
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest C. Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 28 (Day) 1912 (Year)

7. AGE: 2 yrs. 1 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kans.

10. NAME OF FATHER: C. L. Davis

11. BIRTHPLACE OF FATHER (State or Country): Kans.

12. MAIDEN NAME OF MOTHER: Jessie V. Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Davis
(Address) Twin Falls

15.
Filed 9-21 1914 John M. Engle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/19/1914 to 9/19/1914 that I last saw h[illegible] alive on 9/19/1914 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Acute [illegible] diarrhea

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. [illegible], M. D.
9/21/1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. DATE OF BURIAL: Sept 21 1914

20. UNDERTAKER: J. C. Isaacson ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No.
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Hansen
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ezra Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 23 (Day) 1845 (Year)

7. AGE: 69 yrs. 2 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: E. Williams

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Robt McCallum
(Address) Hansen Ida.

15. Filed 9-26 1914 John L. Keyhea Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1914, to Sept 26 1914, that I last saw him alive on Sept 25 1914, and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy
Due to Hemorrhage
(Duration) yrs. mos. 4 ds.
Contributory Senile conditions
(Secondary)
(Duration) yrs. mos. ds.

(Signed) J. R. Morgan M. D.
Sept 26 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 9-27 1914

20. UNDERTAKER: P Marsh. — ADDRESS: T-Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 104
City of Wallace (No. Providence Hosp. St.)
File No. 64
Registered No.
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Dallas Ambrose Freeman
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH: Aug (Month) 10 (Day) 1899 (Year)

7. AGE: 15 yrs. 1 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Bert A. Freeman

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Nora M. Butz

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. W Butz
(Address) Kellogg Idaho

15.
Filed Sept 26 1914 F. Leo Dunphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1914, to Sept 26 1914
that I last saw h-m alive on Sept 26 1914,
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Tubercular
Osteomyelitis
(Duration) yrs. 10 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Dr. Moffett M. D.
Sept 26 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Sept 29 1914

20. UNDERTAKER: Bruce G Worstell — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YUSE-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)

File No. .....
Registered No. 62

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Culhane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: not known (Month) 1 (Day) ..... (Year)

7. AGE: 47 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. C. Culhane
(Address) Deltese Mont

15.
Filed Sept 7 1914 F. Leo Tunley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gunshot wound head—
Suicidal

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Mowery M. D.
Sept 24 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: Sept 26 1914

20. UNDERTAKER: [illegible]
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70

County of Shoshone — Primary Registration District No. 011

City of Wallace (No. 307, Third St. St.) — File No.

If death occurs away from usual residence, give facts called for under special information. — Registered No. 61

2. FULL NAME J. Richardson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 5 (Day) 1 (Year)

7. AGE: 48 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veterinary Surgeon
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West. Va.

10. NAME OF FATHER: Mrs Richardson

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Moss

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. Richardson
(Address) Wallace Ida

15. Filed Sept 19 1914 H. Leo Dunphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15th 1914, to Sept 18th 1914
that I last saw h[illegible] alive on 1914,
and that death occurred on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:
Aneurysm of Aorta

(Duration) yrs. 6 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Thos. F. Brumback M. D.
9/19/14 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Sept 19 1914

20. UNDERTAKER: B. L. Worstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. Hope Hospital St.)
File No.
Registered No. 60
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Aaron Bradbury
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: April (Month) 9 (Day) 1831 (Year)

7. AGE: 83 yrs. 5 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Lewis Bradbury

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Bradbury
(Address) Wallace

15.
Filed Sept 16 1914 F. Leo Dunphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 12 1914, to Sept 14 1914, that I last saw him alive on Sept 14 1914, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Cancer
Chronic Intestinal Nephritis
Arterio Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Intestinal Obstruction

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Howard C. Pearson M. D.
9/15/14 19 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 4 mos. 11 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Calpa, Tenn.

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho
DATE OF BURIAL: Sept 16 1914

20. UNDERTAKER: D G Woodall
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital St.)

File No.
Registered No. 59
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George Mack.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: Irish

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 45 yrs old. (Month) (Day) 1 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Charge of Storage Dept of autos.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Philadelphia Pa.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. E. Grubbs
(Address) Wallace Hospital

15. Filed Sept 15 1914 F. Leo Dunphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1914, to Sept 11 1914, that I last saw h im alive on Sept 10 1914, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) about yrs. mos. ds.

Contributory (Secondary) Exposure

(Duration) yrs. mos. ds.

(Signed) Wm Morgan M. D.

9/11 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Sept 16 1914

20. UNDERTAKER: Bruce G. Wardell — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. ....., ... St.)

Registration District No. 70

Primary Registration District No. 1011

File No. .....

Registered No. 5-8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph W. Reynolds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November 1 (Month) (Day) 1871 (Year)

7. AGE: 43 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Freighting

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Brainard North Dakota

10. NAME OF FATHER: John Reynolds.

11. BIRTHPLACE OF FATHER (State or Country): Kemptville Ontario

12. MAIDEN NAME OF MOTHER: Margaret Higgins

13. BIRTHPLACE OF MOTHER (State or Country): Kemptville Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Rindell

(Address) Helena Mont

15. Filed Sept 17. 1914 — F. Leo Twigley, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10 1914, to Sept. 10 1914, that I last saw h.im alive on Sept 10 1914, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) ..... Yrs. ..... mos. 1/4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Moyer M. D.

Sept 13 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: 9/14 1914

20. UNDERTAKER: Wards Undertaking Co. — ADDRESS: Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gooding
City of Wendell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5th
Primary Registration District No. 2418
(No. ....., ... St.)

File No. 8994
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bert Best

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 7 (Month) 28 (Day) 1914 (Year)

7. AGE: 0 yrs. 0 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wendell

10. NAME OF FATHER: Alvin Best

11. BIRTHPLACE OF FATHER (State or Country): Salden

12. MAIDEN NAME OF MOTHER: Minnie Morton

13. BIRTHPLACE OF MOTHER (State or Country): Falk Iowa, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alvin Best
(Address) Wendell

15.
Filed Oct 28 1914 H E Sands
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1914, to July 28 1914, that I last saw h alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell — DATE OF BURIAL: July 29 1914

20. UNDERTAKER — ADDRESS —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD [redacted]
Bureau [redacted]
File No. [redacted]
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Wendell
Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary A Leland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 17 (Day) 1847 (Year)

7. AGE: 70 Yrs. 8 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woman wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Richard Wilkinson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Nicholson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H. E. Barrett
(Address) Wendell Idaho

15. Filed Oct 1 1914
H E Lamb
Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch. (Month) 3d (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1911, to Mar 3 1914, that I last saw h[illegible] alive on Mar 3 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Dilatation of Heart
& Acute Congestion of Lungs

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Lamb M. D.
Oct 1 1914 (Address) Wendell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell — DATE OF BURIAL: Mar 5 1914

20. UNDERTAKER — ADDRESS: Wendell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake

City of Paris

Registration District No. 513

Primary Registration District No. 2133

(No. ....., ... St.)

File No. 8996

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Bunn Beck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Nov. (Month) 2 (Day) 1887 (Year)

7. AGE: 27 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fred Bunn

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Matilda M. King

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morgan L. Rich

(Address) Paris

15. Filed 10/28/ 1914 C. J. Hutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I~~ we attended deceased from Oct 1 1914, to Oct 6 1914, that I last saw her alive on Oct 6 1914, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Ruptured appendix following confinement

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) organic heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Geo. F. Kelly M. D.
per Chas. Hutton

19..... (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris

DATE OF BURIAL: Oct 8 1914

20. UNDERTAKER: Mrs Clara Stucki

ADDRESS: Paris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & RDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2132
(No. .... St.)

File No. 8997
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Bloomington
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hariet Angeline Welker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. July (Month) 25 (Day) 1839 (Year)

7. AGE: 75 Yrs. 2 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Joseph L. Lish

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Hariet Ann Trip

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Welker
(Address) Bloomington

15. Filed 10/28/ 1914 C. J. Shelton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to Oct 1 1914, that I last saw her alive on Oct 4 1914, and that death occured on the date stated above, at 6 H. M.

The CAUSE OF DEATH* was as follows:
Septicaemia and Nephritis
(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) cancer bladder ?
(Duration 1 yrs. ..... mos. ..... ds.
(Signed) L. B. Hollendorf M. D.
Oct 6 1914 (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bloomington — DATE OF BURIAL: Oct 8 1914

20. UNDERTAKER: J Jacobsen — ADDRESS: Bloomington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Deary
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ... St.)

File No. A 8995
Registered No. 7
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorraine A. Dalberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W	Single

6. DATE OF BIRTH: Oct. (Month) 21 (Day) 1913 (Year)

7. AGE: 0 yrs. 10 mos. 26 ds.
IF LESS than 1 day how many .. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER Lewis P. Dalberg

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Ida Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. C. Faust
(Address) Deary

15. Filed Sept 18 1914 P. C. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 17 1914 to ..... 191..,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Strangulation (smothering)
(accidental)
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. C. Faust M. D.
9/19 1914 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Zion Cemetery	9/19 1914

20. UNDERTAKER	ADDRESS
J. E. Pickard	Deary

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 8993
Registered No. 19

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Feb (Month) 5 (Day) 1828 (Year)

7. AGE
86 yrs. 7 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Minister
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER Samuel Wells

11. BIRTHPLACE OF FATHER (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Mary Irwin

13. BIRTHPLACE OF MOTHER (State or Country) U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.L. Wells
(Address) New Plymouth

15.
Filed Oct 3 1914 J.O. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1914, to Oct 3 1914, that I last saw h... alive on Oct 3 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct 3 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho | DATE OF BURIAL: Oct 4 1914

20. UNDERTAKER: O.K. Adair | ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 9000
Registered No. 20

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma C Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: July 20 (Month) (Day) 1867 (Year)

7. AGE: 47 yrs. 2 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Olaf Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ideen Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maggie Olson
(Address) Payette Ida

15. Filed Oct 10 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October 9 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1914, to Oct. 9 1914, that I last saw her alive on Oct 9 1914, and that death occurred on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis about one year
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Cerebral embolism
(Duration About one year ds.
(Signed) O. F. Avery M. D.
10/10/1914 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Oct 11 1914

20. UNDERTAKER	ADDRESS
D. H. McAdair	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9001

Registered No. 21

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. 0 St.)

2. FULL NAME Fredrick H. Swank

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 1 (Day) 1882 (Year)

7. AGE: 32 yrs. 8 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: James H. Swank

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Martha Arnold

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Swank
(Address) Payette Ida

15. Filed Oct 27 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 25 1914 to Oct. 26 1914, that I last saw him alive on Oct. 26 1914, and that death occurred on the date stated above, at 7:40 a. M.

The CAUSE OF DEATH* was as follows:
Shock from accidental Gun Shot wound of Left Thoracic region
(Duration) 1 yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Crispin Wright M. D.
Oct 26 1914 (Address) Emmett, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence: Kansas

19. ~~PLACE OF BURIAL~~ OR REMOVAL: Brownsville Ore
DATE OF ~~BURIAL~~: Oct 27 1914

20. UNDERTAKER: J. N. Adair
ADDRESS: Payette Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

File No. [illegible]
Registered No. 38

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Estella Orchard
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 25 (Day) 1893 (Year)

7. AGE: 21 Yrs. 5 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Utah

10. NAME OF FATHER: William Joseph Orchard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Maryann Ockwheeler

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Louis Earl Orchard
(Address): Burley

15. Filed 10-10-14 191.... Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12th 1914, to Oct 6 1914, that I last saw h.. alive on Oct 5th 1914, and that death occured on the date stated above, at 12.30 a.m.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) ..... Yrs. ..... mos. 22 ds.
Contributory (Secondary)
(Duration ..... Yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
10-7 1914 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL, OR REMOVAL: Pleasant Hill Cem. | DATE OF BURIAL: 10/7 1914

20. UNDERTAKER: A. L. Watt | ADDRESS: Burley

BYRNS - YORK CO., PTRS. & BKBS. 24652

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

M & K.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9003
Registered No. 6665

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. 1323, Main St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2163

2. FULL NAME Bertha Parsons.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Aug (Month) 29 (Day) 1914 (Year)
7. AGE: ..... yrs. 1 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Sandpoint Idaho
10. NAME OF FATHER: C. E. Parsons
11. BIRTHPLACE OF FATHER (State or Country): Mich
12. MAIDEN NAME OF MOTHER: Mabel Rahlberg
13. BIRTHPLACE OF MOTHER (State or Country): Idaho Iris
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Parsons
(Address) Sandpoint Ida.
15.
Filed Nov 12 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1914, to Sept 28 1914 that I last saw her alive on Sept 28 1914, and that death occurred on the date stated above, at 5 A M.
The CAUSE OF DEATH* was as follows:
Bronchi-Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
Oct 4 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westmond Ida. DATE OF BURIAL: 10/4 1914
20. UNDERTAKER: E M Brown ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [illegible]0004
Registered No. 6-5-6

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2133 Mach.
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Tom Lavin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) single

6. DATE OF BIRTH
..... 1 .....
(Month) (Day) (Year)

7. AGE 56 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Cruiser
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mich.

10. NAME OF FATHER John Lavin

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Bridget Lavin

13. BIRTHPLACE OF MOTHER (State or Country) Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Keegan
(Address) Spokane Wash.

15.
Filed Nov 12 1914 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 6 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1914., to Oct 6th 1914
that I last saw him alive on Oct 3rd 1914
and that death occurred on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:
died sitting in Chair
Heart Failure
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio Sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm McKinnon M. D.
Oct 7 1914 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sandpoint Ida. DATE OF BURIAL 10/9 1914

20. UNDERTAKER E M Pruner ADDRESS S.P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Ponderay
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153 Stark
(No. ....., ... St.)

File No. 9005
Registered No. 337
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edward Gray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 17 1901
(Month) (Day) (Year)

7. AGE: 9 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Student
(b) General nature of industry business, or establishment in which employed (or employer): Public School

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Frank Gray

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Helen Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ben Thompson
(Address): Park Rink Idaho.

15.
Filed Nov 12 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 13 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from By phone on Oct 13 191..., to ..... 191....
that I last saw h..... alive on ..... 191....,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Killed by being struck over heart by batted base ball - probably instantly
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) by permission C. V. Stackhouse M. D.
Nov 12 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was Disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: McArthur Idaho
DATE OF BURIAL: 10/15 1914

20. UNDERTAKER: E. M. Brower.
ADDRESS: Sandpoint.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9006

Registered No. 558

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2153 Page
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Henry Farris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
35 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry business, or establishment in which employed (or employer) Lumber Jack

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Do

12. MAIDEN NAME OF MOTHER Do

13. BIRTHPLACE OF MOTHER (State or Country) Do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Brower
(Address) Sandpoint

15.
Filed Nov 12 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1914, to Oct 22 1914 that I last saw h[illegible] alive on Oct 22 1914, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Acute alcoholism

(Duration) ~ yrs. ~ mos. ~ ds.

Contributory (Secondary) ~

(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) O F Page M. D.
19..... (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was Disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: 10/25 1914

20. UNDERTAKER: E W Brower — ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9007
Registered No. 23

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 125
Primary Registration District No. 2200
(No. Room, Storm Mine St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Drar Ara

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... 1
(Month) (Day) (Year)

7. AGE 26 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER 4 4

13. BIRTHPLACE OF MOTHER (State or Country) 4 4

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R E Walters
(Address) Kaser Idaho

15.
Filed Oct 25 1914 W. H. Dunn Clk
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 18 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental death
due to premature
explosion missed hole
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) Dr Mowery yrs. mos. ds.

(Signed) Dr Mowery M. D.
Oct 19 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Oct 18 1914

20. UNDERTAKER: Bruce & Woestrel — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

YMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M, 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 7200
(No. Interstate Mine St.)

File No. 9008
Registered No. 22
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Daniel Franklin Braud

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH: Oct. (Month) 13 (Day) 1 (Year)
7. AGE: 63 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: Calvin W Braud
11. BIRTHPLACE OF FATHER (State or Country): New York
12. MAIDEN NAME OF MOTHER: L M Blaisdell
13. BIRTHPLACE OF MOTHER (State or Country): New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E Davis
(Address) Ellensburg Wash
15. Filed Oct 2 1914 H C Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 1 (Month) (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw him alive on — 1914,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia Poisoning
Sinking spell Convulsions
(Duration) yrs. mos. 3 Hrs ds.
Contributory (Secondary) Alcoholism
(Duration) 10 yrs. mos. ds.
(Signed) Chas. H. Mowry M D
Oct 2 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Oct 3 1914
20. UNDERTAKER: Bruce & Worsley — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9009
Registered No. 12

1. PLACE OF DEATH.
County of Owyhee
City of De Lamar
Registration District No. 43
Primary Registration District No. 2120
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Frank Lefley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: May (Month) 15 (Day) 1874 (Year)
7. AGE: 70 yrs. 5 mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranches
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Penn.
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Adams
(Address) De Lamar Ida
15.
Filed Oct. 26, 1914 W. H. Schuyler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 23 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 24, 1914, to October 20, 1914 that I last saw him alive on Oct. 20, 1914 and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:
Cancer of prostate and stomach
..... (Duration) one yrs. — mos. — ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Schuyler M. D.
Oct. 26. 1914 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: On Ranch at Trout Creek — DATE OF BURIAL: Oct 24th 1914
20. UNDERTAKER: John Brute — ADDRESS: Silver City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. Y 1

County of Boundary Primary Registration District No. 2158

City of Priest River (No. ....., ... St.)

File No. 9010

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Augustus Dennison

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Divorced~~ Widowed

6. DATE OF BIRTH: April (Month) 17 (Day) 1837 (Year)

7. AGE: 77 yrs. 6 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: William Dennison

11. BIRTHPLACE OF FATHER (State or Country): New York state

12. MAIDEN NAME OF MOTHER: Elenor Jane Goldy

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George W. Dennison
(Address) Priest River Idaho

15. Filed Nov 1st 1914 E D McCaig Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) first (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1914, to Nov. 1st 1914 that I last saw him alive on Oct 28th 1914, and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrage

..... (Duration) — yrs. — mos. ~~four~~ ds.

Contributory (Secondary) Nephritis arteriosclerosis

..... (Duration) Dont know yrs. ..... mos. ..... ds.

(Signed) E D Dennison per E D McCaig M. D.

Nov 1st 1914 (Address) Priest River Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: none

DATE OF BURIAL ..... 191...

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 9011
Registered No. 17

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 312 Main st St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Archibald B. Cook.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
Oct (Month) 13 (Day) 1 (Year)

7. AGE
81 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Iowa.

10. NAME OF FATHER: Alex. Bell

11. BIRTHPLACE OF FATHER
(State or Country) Pa.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Cook
(Address) Lewiston, Idaho

15.
Filed Nov. 10 1914
L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 2nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1914 to Oct 1st 1914, that I last saw h.er alive on Oct 2nd 1914, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Fatal conjunction.
(Duration) about Yrs. 6 mos. ds.
Contributory (Secondary) General Cerebral
(Duration) Yrs. 2 mos. ds.
(Signed) F. A. Haines M. D.
10/9/1914 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Oct 6 1914

20. UNDERTAKER: Kessler — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. [redacted]
Registered No. [redacted]

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Fox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Nov (Month) 29 (Day) 1861 (Year)

7. AGE: 52 Yrs. 10 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: C. Regan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Dougherty

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. J. Carson
(Address)

15. Filed Nov. 10. 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1914, to Oct 5th 1914, that I last saw h[illegible] alive on Oct 5th 1914, and that death occured on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows: Toxemia
Pulmonary Tuberculosis
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration 3 yrs. mos. ds.
(Signed) D. B. Pearson M. D.
19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL 191[illegible]

20. UNDERTAKER: L. J. Carson — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BKBS. 24656

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
(No. ..... St.)

File No. 9213
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nezperce

City of .....

2. FULL NAME Philip Tustnto

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not Known (Month) (Day) (Year)

7. AGE: About 35 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer on R R
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): ,

12. MAIDEN NAME OF MOTHER: ,

13. BIRTHPLACE OF MOTHER (State or Country): ,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Cazzar Corona
(Address) Lewiston

15. Filed Nov. 10 1914 L. J. Burkam Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 11 G M.

The CAUSE OF DEATH* was as follows:
Accidental discharge of shot gun
(Duration) Instant yrs. ..... mos. ..... ds.
Contributory (Secondary) Gun shot wound.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. Cazzar Corona M. D.
19.... (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Oct 12 1914

20. UNDERTAKER: Larson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

File No. 9015

Registered No. 21

County of Nez Perce

City of Lewiston (No.) Orchard tract St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David H. Guilland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. March (Month) 7 (Day) 1869 (Year)

7. AGE: 45 Yrs. 7 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Walla Walla

10. NAME OF FATHER David Galland

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER M. Schmutz

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Rudkin

(Address) Kennewick Wn

15. Filed Nov. 10 - 1914

L. J. Perkins
Local Registrar

SVMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 21- (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h.....alive on ..... 191...,

and that death occured on the date stated above, at 7. a. M.,

The CAUSE OF DEATH* was as follows:

Sub phrenic Abscess

(Duration) not known mos. ..... ds.

Contributory (Secondary) Peritonitis following

(Duration) 3 yrs. — mos. — ds.

(Signed) L. J. Perkins M. D.

10/21 1914 (Address) L. J. Perkins

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 10/23 1914

20. UNDERTAKER: Dawson — ADDRESS: Lewiston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

File No. 9016

Registered No. 22

County of Nez Perce

City of Lewiston Ida (No. 304 - 15th at St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sanford L. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH: Oct. 1 (Month) (Day) 1837 (Year)

7. AGE: 76 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Aaron Miller

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elizabeth Wirth

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel Miller Williams by
(Address) Hanford,

15. Nov. 10 - 1914
Filed Oct 26 1914 L.J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 26 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1914, to Oct 1914 that I last saw h-im alive on Oct. 25 - 1914 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

(Duration) Several yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L J Perkins M. D.
10/26 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 10/28 1914

20. UNDERTAKER: J. Larson — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 96 Nez Perce

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9017

Registered No. 23

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston (No. ..., Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant (E Lee)

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 27 (Day) 1914 (Year)

7. AGE ... Yrs. ... Mos. ... ds. IF LESS than 1 day how many 2 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Idaho

10. NAME OF FATHER: E Lee

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: May Robb

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E Lee
(Address) Woolland Idaho

15. Filed Nov. 10 1914 L J Perkins Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1914, to Oct 27 1914, that I last saw her alive on Oct 27 1914, and that death occured on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth (6 months)

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ... (Duration ... yrs. ... mos. ... ds.

(Signed) Jesse L. Rains M. D.

Oct. 28 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 9/28 1914

20. UNDERTAKER: C J Vasen — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9x
Primary Registration District No. 1009
File No. 9018
Registered No. 24

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mable B. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ♀
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 1st (Day) 1885 (Year)

7. AGE: 29 Yrs. 9 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kans.

10. NAME OF FATHER: L. L. Bodine

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary H. Downing

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Oscar L. Miller
(Address) Lewiston

15. Filed Nov. 10 1914 L. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10th 1914, to Oct 29th 1914, that I last saw h.r alive on Oct 29 1914, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Eclopic or Right Tubal Pregnancy
6 weeks.

(Duration) Yrs. 1 mos. 15 ds.
Contributory (Secondary) Post operative acute dilatation of Stomach.
(Duration) yrs. 2 mos. 1 ds.
(Signed) Edgar L. White M. D.
10/31 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 11/2 1914

20. UNDERTAKER: L. Lassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9019

Registered No. 2524

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. 1620 Main st. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Kline

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1873 (Year)

7. AGE: 41 Yrs. 8 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: Chas DeFore

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Kline

(Address) 1620 Main st

15. Filed Nov 10 - 1914 L. J. Perkins Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1914, to Oct 31 1914, that I last saw her alive on Oct 31 1914, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) C. C. Casson M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 191

20. UNDERTAKER: Casson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 9020
Registered No. 96

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Baby Fraday

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: 10 (Month) 31 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lewiston

10. NAME OF FATHER Floid Carrell

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Cloe Fraday

13. BIRTHPLACE OF MOTHER (State or Country) Pleasant Hope, Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A F Harris M D
(Address) Lewiston

15.
Filed Nov 10 1914 L. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/31/1914, to 10/31/1914, that I last saw her alive on 10/31/1914, and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A F Harris M. D.
10/31/1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: C J Vassar
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

File No. 9021

Registered No. 64

County of Bingham

City of Black Foot

(No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caralina Kilbach Sink

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: Aug (Month) 13 (Day) 1863 (Year)

7. AGE: 51 yrs. 1 mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Joseph Kilbach

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Johanner Krajfle

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) mrs Josepha Mentz

(Address) Elenora mont

15. Filed Oct. 6th 1914 W E Patric Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1914 to Oct 3 1914, that I last saw her alive on Oct 3 1914, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemarrhage

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. J. Simmons M. D.

19 (Address) Black foot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos. 60 days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence: Tabor Idaho

19. PLACE OF BURIAL OR REMOVAL: Pluvna Mont. DATE OF BURIAL ... 191...

20. UNDERTAKER: E J Ruck ADDRESS Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9022
Registered No. 65

1. PLACE OF DEATH.
Registration District No. 121
Primary Registration District No. 2194
County of Bingham
City of Blackfoot (No. Idaho Insane Asylum St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ole A. Wiste

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
March 11 1875
(Month) (Day) (Year)

7. AGE
39 yrs. 6 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Ole Wiste

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE ~~BEST OF~~ MY KNOWLEDGE
(Informant) Geo. V. Hyde
(Address) Blackfoot

15. Filed Oct 7th 1914 M. E. Ward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
October 5th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1913, to October 5 1914, that I last saw him alive on October 5 1914, and that death occurred on the date stated above, at 12-0 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorrhage

— (Duration) — Few minutes yrs. mos. ds.
Contributory (Secondary) Paresis
Dont Know (Duration) 1 yrs. mos. ds.

(Signed) Geo. V. Hyde M. D.
Oct 6 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 6 mos. 29 days. In the State 8 yrs. — mos. — days.
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Boise

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ingham Cemetery	Oct 7 1914

20. UNDERTAKER E. J. Funk ADDRESS Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1923
Registered No. 66

Registration District No. 121
Primary Registration District No. 1007

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. North Taylor St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Mary Parkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 1 (Day) 1914 (Year)

7. AGE ... Yrs. ... Mos. 5 ½ ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Bingham Co. Idaho

10. NAME OF FATHER Frank S. N. Parkinson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ora Mae Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank S. N. Parkinson
(Address) Blackfoot, Idaho.

15. Filed Oct 8 1914 M. E. Parker Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Oct 7 1914, that I last saw her alive on Oct 7 1914, and that death occured on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Brain Hemorrhage

(Duration) ... Yrs. ... mos. 5 ½ ds.

Contributory (Secondary) Protracted Labor

(Duration ... yrs. ... mos. ... ds.

(Signed) W. W. Beck M. D.
10/8 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Gore City Cem. Blackfoot
DATE OF BURIAL: Oct 8 1914

20. UNDERTAKER: F. M. Parkinson
ADDRESS: Blackfoot Idaho.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. ....., ... St.)

Registration District No. 121
Primary Registration District No. 2140

File No. 9021
Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roscoe Hatmaker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March (Month) 11 (Day) 1893 (Year)

7. AGE: 21 yrs. 6 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Peter Hatmaker

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Mary L. Grant

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Davis M D
(Address) Blackfoot Idaho

15. Filed Oct 8 1914 M E Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Oct 4 1914
that I last saw him alive on Oct 4 1914
and that death occurred on the date stated ~~above~~, at 5:30 M. Oct 6
The CAUSE OF DEATH* was as follows:
Septic Peritonitis

..... (Duration) ..... yrs. ..... mos. 6 ds.
Contributory [redacted] Appendicitis
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Davis M. D.
Oct 6 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Immaculate Conception DATE OF BURIAL: Oct 8 1914

20. UNDERTAKER: E J Peck ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham — Registration District No. 121

City of Blackfoot — Primary Registration District No. 2194

(No. Idaho Insane Asylum St.)

File No. 9025

Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Terry Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 29 (Day) 1893 (Year)

7. AGE: 21 yrs. 5 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Albion, Idaho

10. NAME OF FATHER: Miles G. Robinson

11. BIRTHPLACE OF FATHER (State or Country): Clayton, Ill

12. MAIDEN NAME OF MOTHER: Mary E. Hammer

13. BIRTHPLACE OF MOTHER (State or Country): Genesee, Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo D Boyle
(Address) Blackfoot, Idaho

15. Filed Oct 10 1914 — M. E. Tate, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 9th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1913, to Oct 9 1914, that I last saw h in alive on Oct 9 1914 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) — yrs. — mos. 3 ds.

Contributory (Secondary) Shot in Brain Accidentally

(Duration) 19 yrs. mos. ds.

(Signed) Geo D Boyle M. D.

Oct 10 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho — DATE OF BURIAL 191...

20. UNDERTAKER: E J Funk — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9026
Registered No. 67

Registration District No. 121
Primary Registration District No. 2194

1. PLACE OF DEATH.
County of Bingham
City of Taber (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paulena Mayer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 20 (Day) 1888 (Year)

7. AGE: 25 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Russia

10. NAME OF FATHER: Chris Schuler

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Carey Bregenzer

13. BIRTHPLACE OF MOTHER (State or Country): South Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gottlieb Mayer
(Address) Taber Idaho

15. Filed Oct 20 1914 W. C. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1914, to Oct 16 1914, that I last saw her alive on Oct 16 1914, and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Hypostasis of Brain

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Heber B. Cooper, M. D.
19 ..... (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marland Idaho — DATE OF BURIAL: Oct 21 1914

20. UNDERTAKER: Gottlieb Mayer — ADDRESS: Labor Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9027

Registered No. 70

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Biorn Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. April 2 1914
(Month) (Day) (Year)

7. AGE ..... Yrs. 6 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ~

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bingham Co. Idaho

10. NAME OF FATHER Joseph Waddoups

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Agnes Cristena Biorn

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Waddoups Wood

(Address) Blackfoot, Idaho

15. Filed Oct 22 1914 M. G. Petrie Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1914, to October 20 1914, that I last saw him alive on Oct. 20 1914, and that death occured on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH* was as follows:

Unknown infection

(Duration) ~ Yrs. ~ mos. 20 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.

10/21/1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sunset City Cem. Blackfoot — DATE OF BURIAL: Oct 22 1914

20. UNDERTAKER: J. W. Wood — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9028
Registered No. 71

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
~~City of~~ Wapello (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Frekelton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: 10 (Month) 26 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. 2 hrs. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wapello, Bingham Co. Ida

10. NAME OF FATHER: Samuel H. Frekelton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Zilpah Cutler

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Saml H. Frekelton
(Address) Wapello, Ida

15. Filed Oct 27 1914 M E Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-26, 1914, to 10-26 1914, that I last saw him alive on 10-26 1914 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Debility, due to premature birth about 7 mos

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Eccentric Condition of Mother
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Flower M. D.
10-26 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wapello Ida — DATE OF BURIAL: Oct 27 1914

20. UNDERTAKER: Albert Blair — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9029
Registered No. 16

1. PLACE OF DEATH.
County of Custer
City of Mackay
Registration District No. 109
Primary Registration District No. 2187
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jno Sovala

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ~~Sept~~ Nov 11 ~~20~~ (Month) (Day) 1913 (Year)

7. AGE: ..... yrs. 10 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mackay Ida

10. NAME OF FATHER: Enrique Sovala

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Maria Drascada

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno Sologa
(Address) Mackay Ida

15. Filed 10/21 1914 F. P. Richards Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 20 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1914, to Sept 20 1914
that I last saw h~~im~~ alive on Sept 20 1914
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Entero colitis acute

..... (Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) —
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E. Mason M. D.
10/21 1914 (Address) Mackay

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay Id
DATE OF BURIAL: Sept 22 1914

20. UNDERTAKER: Chas D Baker
ADDRESS: Mack

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9030

Registered No. 119

1. PLACE OF DEATH.

County of Bonneville

City of Iecon

(No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 3 1 7 0

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Olive Stoker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.

Aug. (Month) 27 (Day) 1912 (Year)

7. AGE

2 Yrs. 2 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER Albert M. Stoker

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER Eva L. Carter

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert M. Stoker

(Address) Ida[illegible] Falls, R. 7, Box 42

15.

Filed Oct 31 1914 C. J. Spencer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 28 1914

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 27 1914, to Oct. 28, 1914, that I last saw him alive on Oct. 28, 1914, and that death occured on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Accidental Arsenical Poisoning

(Duration) ..... Yrs. ..... mos. 9 hours.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A. Mellen M. D.

(Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Willow Creek cemetery — DATE OF BURIAL: Oct 3 1914

20. UNDERTAKER: Thos. W. Muhleman — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2103
(No. ....., ... St.)

File No. 9031
Registered No. 108

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Eliz. Branca

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH.
Dec (Month) 29 (Day) 1911 (Year)

7. AGE
2 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER R. E. Branca

11. BIRTHPLACE OF FATHER (State or Country) ~~Mary J. Lou~~ Ill.

12. MAIDEN NAME OF MOTHER Mary J. Cunningham

13. BIRTHPLACE OF MOTHER (State or Country) Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. E. Branca
(Address) Idaho Falls

15. Filed Oct 27 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1914, to Oct 27 1914, that I last saw h[illegible] alive on Oct 27 1914, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Fracture skull - Thrown from Load

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
10-27 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 10/25 1914

20. UNDERTAKER: [illegible] Dimmoody
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9032

Registered No. 107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2130

(No. ....., ... St.)

2. FULL NAME Alva Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE

42 Yrs. - Mos. - ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Trapper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Okla

10. NAME OF FATHER -

11. BIRTHPLACE OF FATHER

(State or Country) -

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER -

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. W. Mackleman

(Address) Idaho Falls

15.

Filed Oct 22 1917.

Local Registrar

STUB - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 19 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Manley Coroner M.D.

Oct 19 17 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: Oct 22 1917

20. UNDERTAKER: Thos. W. Mackleman — ADDRESS: Ida. Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9033
Registered No. 106

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls Ida (No. ....., ... St.)
Registration District No. 73
Primary Registration District No. 2150

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude Rasmussen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. May (Month) 9 (Day) 1854 (Year)
7. AGE: 60 Yrs. 5 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Denmark
10. NAME OF FATHER: Jens Martinsen
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Mary
13. BIRTHPLACE OF MOTHER (State or Country): Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna Rasmussen
(Address) Idaho Falls
15. Filed Oct 16 1914 — E. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1914, to Oct 14 1914, that I last saw her alive on Oct 14 1914 and that death occured on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 2nd ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. [illegible] M. D.
Oct 16 1914 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 10/16 1914
20. UNDERTAKER: E. G. Dimmock — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9034
Registered No. 10 V

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2170
(No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest L. Molen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. January (Month) 21 (Day) 1876 (Year)
7. AGE: 38 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Lehi, Ut.
10. NAME OF FATHER: Francis M. Molen
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Emma Laurence
13. BIRTHPLACE OF MOTHER (State or Country): Indiana
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Perry Molen By C.E.S.
(Address) Ida Falls #3
15. Filed Oct 16 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1913, to ..... 191..., that I last saw h.. alive on Nov 15 1913, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Thuper M. D.
19.... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon, Ida
DATE OF BURIAL: 10/8 1914
20. UNDERTAKER: C. E. Linwoody
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-35 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
(No. ..... St.)

File No. 9035
Registered No. 104

1. PLACE OF DEATH.
County of Bingham
City of Ucon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Petrina Holst

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. March (Month) 28 (Day) 1842 (Year)
7. AGE: 72 Yrs. 6 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
9. BIRTHPLACE (State or Country) Denmark
10. NAME OF FATHER Fredrickson
11. BIRTHPLACE OF FATHER (State or Country) Denmark
12. MAIDEN NAME OF MOTHER ~~~~
13. BIRTHPLACE OF MOTHER (State or Country) ~~~~
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Holst
(Address) Ucon Ida.
15. Filed Oct 16 1914 C. E. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1914, to Oct 3 1914, that I last saw h alive on Oct 2 1914, and that death occured on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia
(Duration) 5 Yrs. mos. ds.
Contributory (Secondary) Exposure
(Duration) 1 D Yrs. mos. ds.
(Signed) C. E. Parkinson M. D.
10/16 1914 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Annis Idaho — DATE OF BURIAL: 10-5 1914
20. UNDERTAKER: C. G. Linwood — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STUB - YORK CO., PTRS. & STNRS. 94658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 2140
File No. 9036
Registered No. 103

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leona May Howell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W-

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 18 (Day) 1914 (Year)

7. AGE: ..... Yrs. 4 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L. V. Howell

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Tena Ashcraft

13. BIRTHPLACE OF MOTHER (State or Country) N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. L. V. Howell
(Address) Ca[illegible]

15. Filed Oct 11 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1914, to Oct 10 1914, that I last saw her alive on Oct 10 1914 and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.
Exhaustion
(Duration) ..... Yrs. ..... mos. 2 hrs. ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Oct 11 1914 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. F. | DATE OF BURIAL: 10-11-1914

20. UNDERTAKER: Thos. W. McMahon | ADDRESS: I. Falls

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. ____

County of Bonneville

Primary Registration District No. ____

City of Ucon

(No. ____, ____ St.)

File No. 1 9038

Registered No. 1 1

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH: Oct (Month) 6 (Day) 1914 (Year)

7. AGE: ____ yrs. ____ mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or 30 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry business, or dstablishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Earl John John Lewis

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Susan Mae Harmon

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah J. Simmons

(Address) Ucon Ida.

15. Filed Oct 9 1914 Earl [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1914, to Oct 6 1914, that I last saw h[illegible] alive on Oct 6 1914, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Premature birth
6 mo. 1/2 Just

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Earl [illegible] M. D.

Oct 9 1914 (Address) Ucon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ucon cemetery	Oct 7 1914
20. UNDERTAKER	ADDRESS
[illegible]	—

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 66

Primary Registration District No. 2146

File No. 9039

County of Latah

City of Bovill (No. Bovill Hospital St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Palmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

42 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumber Jack

(b) General nature of industry business, or establishment in which employed (or employer) Potlatch Lbr Co

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E B Flanders

(Address) Bovill Ida

15.

Filed Oct 10 1914 J L Shampine
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1914, to Oct 8 1914

that I last saw him alive on Oct 8 1914

and that death occurred on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary) Albuminuria Tremens

(Duration) yrs. mos. ds.

(Signed) H B Gibson M. D.

10/8 1914 (Address) Bovill Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bovill Ida — DATE OF BURIAL: Oct 11 1914

20. UNDERTAKER: J L Shampine — ADDRESS: Bovill Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 120
County of Cassia Primary Registration District No. 3199
City of Oakley (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
File No. 9040
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rada Critchfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH June 15 1914
(Month) (Day) (Year)

7. AGE ..... yrs. 3 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Abraham Critchfield

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Maud McIntosh

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Abe Critchfield
(Address) Oakley Idaho

15. Filed 9/28 1914 E. O. Cohan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 8, 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1914 to Sept 20 1914 that I last saw h in alive on Sept 20 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Marasmus
and Intrinsic Convulsions

(Duration) ..... yrs. 3 mos. ..... ds.
Contributory (Secondary) Pertussis
(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) E. O. Cohan M. D.
9/27 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Oakley Idaho | DATE OF BURIAL 9-22 1914

20. UNDERTAKER Jos Burrison | ADDRESS Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. H 2041
Registered No. 17

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 3199
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Sophia Moultrie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. March (Month) 24 (Day) 1848 (Year)
7. AGE: 65 Yrs. 6 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Denmark
10. NAME OF FATHER: A. P. Mortensen
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Peterson
13. BIRTHPLACE OF MOTHER (State or Country): Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Moultrie
(Address) Basin
15. Filed 9/28 1917 E. P. Coheen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 8th (Day) 1917 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 22 1917, to Aug 19 1917, that I last saw h[illegible] alive on Aug 19 1917, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs pericarditis probably involved (Duration) about 4 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. K. Dickson M. D.
Sept 19 17 (Address) Oakley Idaho
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL: Basin — DATE OF BURIAL: Sept 10 1917
20. UNDERTAKER: P. P. Jagers. — ADDRESS: Burns

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 7199
File No. 17 9042
Registered No. 18

1. PLACE OF DEATH.

County of Cassia
City of Oakley
(No. ....., ... St.)

If death occurs away from usual residence give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Ernest Rowley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. August (Month) 15 (Day) 1913 (Year)
7. AGE: 1 Yrs. 1 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Greer, Apacheco, Arizona
10. NAME OF FATHER David Lyman Rowley
11. BIRTHPLACE OF FATHER (State or Country) Nephi, Juabco., Utah.
12. MAIDEN NAME OF MOTHER Clara Luella Steiner
13. BIRTHPLACE OF MOTHER (State or Country) Colonia pacheco, Chih. Mex
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Lyman Rowley
(Address) Oakley Idaho
15. Filed 1-6 1914 E D Cohen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 4th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 3 - 5 P.M. 1914, to Oct 4 2 A.M. 1914, that I last saw him alive on Oct 4 - 2 P.M. 1914, and that death occured on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. O. Rees M. D.
10/3 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: Oct 5 1914
20. UNDERTAKER: H C Haight — ADDRESS: Oakley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11 9043

Registered No. 19

1. PLACE OF DEATH.

County of Cassia

City of Oakley

(No. ....., ... St.)

Registration District No. 170

Primary Registration District No. 2144

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matilda Ann Mecham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb. (Month) 14 (Day) 1856 (Year)

7. AGE: 58 Yrs. 7 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Norton Ray Tuttle

11. BIRTHPLACE OF FATHER (State or Country): Connecticut

12. MAIDEN NAME OF MOTHER: Helen E. Uttley

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Jas Mecham

(Address): Oakley Idaho

15. Filed 11 – 6 1914

E P Oleson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 1st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1914, to Oct 1st 1914, that I last saw her alive on Oct 1st 1914, and that death occured on the date stated above, at 8.30 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism (Fatally)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration 4 yrs. 1 mos. ..... ds.

(Signed) E. P. Oleson M. D.

11/3 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: Oct. 3 1914

20. UNDERTAKER: H C Haight — ADDRESS: Oakley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Saldin
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 51
Primary Registration District No. 7138
(No. ....., ... St.)

File No. 9045
Registered No. 14
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George H Abbott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 22 (Day) 1828 (Year)

7. AGE: 85 yrs. 11 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Pa,

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G H Abbott
(Address) Soldier

15.
Filed 10-16 1914 D O Higgs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1914, to Oct 15 1914, that I last saw h[illegible] alive on Oct 14 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Senility, No illness
a Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D O Higgs M. D.
10-16 1914 (Address) Saldin

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Saldin
DATE OF BURIAL: 10-18 1914

20. UNDERTAKER: Sig Mosel
ADDRESS: Saldin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 10672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Adams

Primary Registration District No. 20 11

City of Fruitvale

(No. ....., ... St.)

File No. 9016

Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bradma Glenn

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: 10 (Month) 6 (Day) 1827 (Year)

7. AGE: 87 yrs. 0 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn -

10. NAME OF FATHER: Marshall.

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Hood.

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J J Glenn

(Address) Fruitvale - Idaho

15.

Filed 11-1- 191 4 Frank C Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1914, to ..... 191..., that I last saw h[illegible] alive on Oct 26 1914 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Gastric Hip and Internal
injuries

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank C Brown M. D.

10-28 1914 (Address) Council Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council — DATE OF BURIAL: 10-28 191 4

20. UNDERTAKER: Robt Young — ADDRESS: Council

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Adams

Primary Registration District No. 2011

File No. 9047

City of Council

(No. ....., ... St.)

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Draper

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Oct. (Month) 22 (Day) 1841 (Year)

7. AGE

72 yrs. 11 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jim W Draper

(Address) .....

15.

Filed 10-1- 1914 Frank V Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

9- (Month) 27- (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 19 1914, to ..... 191..., that I last saw h[illegible] alive on Sept. 27 1914 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Prostate

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E. Brown M. D.

10-1 1914 (Address) Council Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Council	9-28 1914

20. UNDERTAKER	ADDRESS
Robt Young	Council

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Kootenai

Primary Registration District No. 3 11

City of Coeur d'Alene

(No. ....., ... St.)

File No. 9048

Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Davis

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: July (Month) 4 (Day) 1912 (Year)

7. AGE: 2 yrs. 2 mos. 26 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Byron Davis

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Tilda Andersen

13. BIRTHPLACE OF MOTHER (State or Country) Col -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Byron Davis

(Address) .....

15. Filed 10-9- 1914 Frank R Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1914, to Sept 30 1914, that I last saw h[illegible] alive on Sept 30 1914, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Ileo Cholitis & Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank R Brown M. D.

10-1 1914 (Address) Comd

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Comd — DATE OF BURIAL: 10-1 1914

20. UNDERTAKER: Robt Young — ADDRESS: Comd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
File No. 9049
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Parma
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Valeria Hervey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W	married

6. DATE OF BIRTH.
Mch (Month) 27 (Day) 1877 (Year)

7. AGE
35 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lexington Ills

10. NAME OF FATHER E. W. Edwards.

11. BIRTHPLACE OF FATHER (State or Country) Do not Know

12. MAIDEN NAME OF MOTHER Do not Know

13. BIRTHPLACE OF MOTHER (State or Country) " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Hervey
(Address) Parma Idda.

15.
Filed Oct 1 1914 Lulu Waldrop Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Oct 1 1914, that I last saw her alive on Oct 1 1914, and that death occured on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:
Poisoning by carbolic acid
(Suicidal)

..... (Duration) — Yrs. — mos. — ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.
10-2 1914 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Roswell	Oct 3 1914
20. UNDERTAKER	ADDRESS
Peckham Case Co	Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 2007

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. H 9 9050

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon Co

City of Rockwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sing

6. DATE OF BIRTH. July (Month) 29 (Day) 1914 (Year)

7. AGE: 0 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canyon Co Ida

10. NAME OF FATHER: William Robinson

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Rachael Smith

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Henry Robinson

(Address) Parma Ida

15.

Filed Oct 12 1914

Lulu Waldorf
Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1914, to Oct 11 1914, that I last saw h— alive on Oct 11 1914 and that death occured on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(Duration) ~~Yrs.~~ ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W W Mulkey M. D.

19..... (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Roswell Cemetery — DATE OF BURIAL: Oct 12 1914

20. UNDERTAKER: Burcham Case Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Canyon

Primary Registration District No. 2007

City of Parma

(No. ..... St.)

File No. 15-9051

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Stewart Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 26 (Day) 1842 (Year)

7. AGE: 72 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: William Hamilton

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary White

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catharine Hamilton

(Address) Parma Ida

15.

Filed Oct 19 1914 Lulu Waldron Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased from ..... 191..., to ..... 191..., that I last saw ~~h~~ alive on ..... 191..., and that death occured on the date stated above, at 7-40 P.M.

The CAUSE OF DEATH* was as follows:

Natural Causes

(No inquest held)

(Duration) ..... Yrs. ..... mos. ..... ds.

~~Contributory~~ (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F K Robinson Coroner M. D.

19.... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma Ida — DATE OF BURIAL: 10-20 1914

20. UNDERTAKER: J H Kellar — ADDRESS: Parma

Fill out all information called for. Every item should be carefully supplied. Age should be stated EXACTLY, FRACTIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9052

Registered No.

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017

2. FULL NAME Comodore Perry Wyckoff

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: May (Month) 19 (Day) 1851 (Year)

7. AGE: 63 yrs. mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Mac Garrett Wyckoff

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Agnes McKee

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Alice [illegible]
(Address): Jerome Idaho

15.
Filed Oct 18 1914 E. D. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1914, to Oct 18 1914
that I last saw him alive on Oct 18 1914,
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John F. Thompstone M. D.
Nov 5 1914 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR ~~REMOVAL~~: Jerome Ida
DATE OF BURIAL: 10-19 1914

20. UNDERTAKER: D. A. Peterson
ADDRESS: Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017
(No. ....., ... St.)

File No. 9053
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Finch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	white	Widow

6. DATE OF BIRTH
Nov (Month) 22 (Day) 1914 (Year)

7. AGE
76 yrs. 11 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Jethro Robbins

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Workman

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Finch
(Address) Arnold Neb.

15. Filed Nov 5 1914 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1914, to Nov 4 1914, that I last saw her alive on Nov 4 1914, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar
(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) Heart failure
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. D. Piper M. D.
Nov 5 1914 (Address) E. D. Piper

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bryan Neb	Nov 5 1914
20. UNDERTAKER	ADDRESS
A. E. Thompson	Loading

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 9053

Name Mary Ann Flinch

Date of Death November 4, 1914

Cause of Death Lobar Pneumonia

Contributary Cause of death Heart Failure

(Sign here) E. D. Piper M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

Primary Registration District No. 1017-2017

File No. 9054

County of Lincoln

City of Jerome

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs May Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 26 (Day) 1881 (Year)

7. AGE: 33 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. S. Harrison

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Sandberg

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ben F. Parker

(Address) Jerome Idaho

15. Filed Oct 26 1914 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1914, to Oct 25 1914, that I last saw her alive on Oct 25 1914, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary) Diabetic Coma

(Duration ..... yrs. ..... mos. 2 ds.

(Signed) E. D. Piper M. D.

10/25 1914 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL 191

20. UNDERTAKER: J. E. Goseman — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2055
Registered No. 12

1. PLACE OF DEATH.
County of Nez Perce
City of Gifford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

2. FULL NAME Edwin B Osborn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: January (Month) 3rd (Day) 1849 (Year)

7. AGE: 64 yrs. 9 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Hiram A Osborn

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Louisa Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret E Osborn
(Address) Tacoma Wash 5907 So Thompson

15. Filed 10 - 8 1914 E E. Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1914, to Oct 4 1914, that I last saw him alive on Oct 3 1914 and that death occurred on the date stated above, at ~ M.

The CAUSE OF DEATH* was as follows:
Endocarditis

..... (Duration) ~ yrs. ~ mos. 5 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Watts M. D.
10-8 1914 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gifford Idaho — DATE OF BURIAL: 10-7 1914

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9057

Registered No.

1. PLACE OF DEATH.
County of Elmore
City of King Hill
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2021
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Audrey Burnice Crockett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Oct. (Month) 18th (Day) 14 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many. 14 hrs. or ..... min.?

8. OCCUPATION: none
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): King Hill Idaho

10. NAME OF FATHER: Alvin D. Crockett

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Emma Jensen

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Davis
(Address) Glenn's Ferry Idaho

15.
Filed Oct. 19th 1914 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 18th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11th, 1914, to Oct. 18th, 1914, that I last saw him alive on Oct. 18th, 1914, and that death occurred on the date stated above, at 1:30 P M.

The CAUSE OF DEATH* was as follows:
Asphyxia Pallida
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
Oct. 18 1914 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
King Hill Idaho	Oct. 19th 1914
20. UNDERTAKER	**ADDRESS**
A. D. Crockett	King Hill

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9058
Registered No. 11

1. PLACE OF DEATH.
County of Lewis
City of Nezperce (No. ....., ... St.)
Registration District No. 47
Primary Registration District No. 2124

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Brock

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Oct 14 1848 (Month) (Day) (Year)

7. AGE: 65 yrs. 11 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hse.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: W. Cunningham

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Sarah Cunningham

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. John Seigneur.
(Address) Nezperce Idaho

15. Filed Nov. 2 1914 J. F. Jones, M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 1 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1914, to Oct 1, 1914 that I last saw h.. alive on Oct 1 1914 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.
Contributory (Secondary) Lues

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. A. Jeffreys M. D.
11-7 1914 (Address) Nezperce Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce Idaho
DATE OF BURIAL: Nov 2 1914

20. UNDERTAKER: P. S. Miller
ADDRESS: Nezperce

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9059
Registered No. 10

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47
Primary Registration District No. 2124
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Zelia Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 14 1890 (Month) (Day) (Year)

7. AGE: 24 yrs. 1 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Work
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): S. D.

10. NAME OF FATHER: W. C. Quigley

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Donaldson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Quigley
(Address) Enderlin N. Dak.

15.
Filed Nov 2 1914 J. F. Jones, M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 30 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1914, to Sept 29 1914
that I last saw her alive on Sept 29 1914
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Eclampsia (Puerperal)

(Duration) ..... yrs. ..... mos. 12 ds.
Contributory (Secondary) Childbirth
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) O. A. Jeffreys M. D.
11-2 1914 (Address) Nezperce Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce Ida.
DATE OF BURIAL: Oct 1 1914

20. UNDERTAKER: P. E. Miller
ADDRESS:

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 47

Primary Registration District No. 2124

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9060

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis

City of Nezperce

2. FULL NAME Harry Murray Jones

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 9 (Day) 1881 (Year)

7. AGE: 33 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Physician & Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER Geo. A. Jones

11. BIRTHPLACE OF FATHER North Carolina (State or Country)

12. MAIDEN NAME OF MOTHER Lillie Lyle

13. BIRTHPLACE OF MOTHER North Carolina (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gilmer A. Jones

(Address) Nezperce, Idaho.

15. Filed Nov 2 1914

J. F. Jones, M. D. Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29 1914, to Oct. 4 1914, that I last saw h[illegible] alive on Oct. 4 1914, and that death occured on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Meningitis (primary)

..... (Duration) ..... Yrs. ..... mos. 5 days

Contributory (Secondary) Pneumonia, Lobar

..... (Duration ..... yrs. ..... mos. 5 ds.

(Signed) O. A. Jeffrey M. D.

10-5 1914 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 2 mos. ..... days. In the State 6 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Nezperce

Former or usual residence Nezperce, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Nezperce, Idaho — DATE OF BURIAL: Oct 6 1914

20. UNDERTAKER: Perry E. Miller — ADDRESS: Nezperce Idaho

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Mountain

Registration District No. 36
Primary Registration District No.
(No. ....., ... St.)

File No. P 9061
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Franklin Wilson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH: Aug - 19 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Twin Falls Co. Idaho

10. NAME OF FATHER: Arthur Wilson

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Bessie M Hays

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. F. Hays
(Address) Kimberly Idaho

15.
Filed Oct - 28 1914 J M Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ did not attend 191 ~~to~~ 191
that I last saw him alive Dec 25 191
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Probably Marasmus as the best diagnosis I could make from their description. about 2 mos. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Davis M. D.
Oct 24 1914 (Address) Kimberly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Artesian City
DATE OF BURIAL: Oct 26 1914

20. UNDERTAKER: None
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 63

Primary Registration District No. 2143

File No. 9062

County of

City of (No. , St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis R. Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: W

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1855 (Year)

7. AGE: 59 yrs. 5 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Wilburn Neal

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Susan Butler

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. F. R. Neal

(Address) Hartline Wash.

15. Filed Oct 31 1914 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191 , to — 191 , that I last saw h— alive on — 191 , and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Apoplexy

Sudden death

(Duration) yrs. mos. ds.

Contributory (Secondary): none apparent

(Duration) yrs. mos. ds.

(Signed) J. E. Hoyt, M. D.

Oct 31 1914 (Address) Kelvedreck Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Hartline Wash — DATE OF BURIAL: 191

20. UNDERTAKER: J. C. Groseclose — ADDRESS: Juliaetta Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 7054
File No. 9063
Registered No. 39

1. PLACE OF DEATH.
County of Ada
City of near Meridian
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. (Month) (Day) 1 (Year)
7. AGE: about 28 Years ..... Mos. ..... ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Profession or kind of work: Farm hand
(b) Nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Oregon
10. NAME OF FATHER: A. S. Brown
11. BIRTHPLACE OF FATHER (State or Country): American
12. MAIDEN NAME OF MOTHER: [redacted] Donahough
13. BIRTHPLACE OF MOTHER (State or Country): American
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. T. Mills
(Address) Weiser Ida
15. Filed 7-12 1914 W. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 11 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead ~~1914~~ to found ~~1914~~, that I last saw h~~e~~ alive on Sept 11 1914, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accident run over by Right of way Oregon Short Line Train Eastbound at Mora and found dead
(Duration) ..... Yrs. ..... mos. ..... ds.
~~Contributory~~ ~~(Secondary)~~ Sept. 11th 1910 1st P. M. by Helper crew 772
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Adolph L. Schreiber M. D.
1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: Sept. 13 1914
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9064

Registered No. 240

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 7004

County of Ada

City of Boise (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Oliver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) — (Day) — (Year) 1825

7. AGE: 89 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Veteran Civil War

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Wil. Oliver

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Stephenson

(Address) Boise Idaho

15. Filed 9-12 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 1906, to 9/10 1914, that I last saw him alive on 9/10 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Contusions from a fall

(Duration) — yrs. — mos. — ds.

(Signed) Fred A Dillenges M. D.

9/12 1914 (Address) Safe Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hillcrest

DATE OF BURIAL: Sept 13 1914

20. UNDERTAKER: Troy Summers

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9065
Registered No. 41

1. PLACE OF DEATH.
County of Ada
City of Near Boise
(No. ....., ... St.)
Registration District No. 8
Primary Registration District No. 2004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earnest Hubert Mobberley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 26 (Day) 1911 (Year)

7. AGE: 2 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Caldwell Ida

10. NAME OF FATHER: Percy Mobberley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Emily Hawkins

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Percy Mobberley
(Address) Boise Idaho.

15. Filed 9-26 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 3:20 P.M.
The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Edward Bonn M. D.
9/26 1914 (Address) 208 Bonn Bldg

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho — DATE OF BURIAL: Sept 27 1914
20. UNDERTAKER: Ivy & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24859

CERTIFICATE OF DEATH

City of Boise (No. Soldiers Home St.) Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Barr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Not Obtainable (Month) (Day) 1833 (Year)

7. AGE: 81 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Not Obtainable

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. G. Burnett
(Address) Soldiers' Home

15.
Filed 9-30 1914 M. O. Parker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1912, to Sept 29 1914, that I last saw h[illegible] alive on Sept 29 1914, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Edwards M. D.

9/30 1914 (Address) Salt Block

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 1 1914

20. UNDERTAKER: Terry & Summers — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9067

Registered No. 244

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 110 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James M. Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. Oct 11 (Month) 11th (Day) 1834 (Year)

7. AGE: 79 Yrs. 11 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer): New York State

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Russell Pierce

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Rosa Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. E. Pierce,

(Address) Pocatello Idaho,

15. Filed 9-30 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1914, to Sept 29 1914, that I last saw h— alive on 29th Sept 1914 and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrage

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Arteria Sclerosis

(Duration yrs. mos. ds.

(Signed) R E Pierce M. D.

19.... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/30 1914

20. UNDERTAKER: Edwards & Hedin Boise — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SONS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 6004

(No. 1213 N. 5th St.)

File No. 9068

Registered No. 240

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susan Evelyn Pierce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: woman

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) 16 (Day) 1866 (Year)

7. AGE: 47 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Waukesha Wis.

10. NAME OF FATHER: Mark H. Short

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Evelyn Baldwin

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Genevieve Pierce

(Address) Boise Idaho

15. Filed 9-25 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 24th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1914, to Sept 24th 1914, that I last saw h.r alive on Sept 24th 1914, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John Barnes M. D.

Sept 24 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs. 9 mos. ..... days. In the State 8 yrs. 9 mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/25 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9069

Registered No. 239

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 610 Ash St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	Married

6. DATE OF BIRTH. Not Obtainable (Month) (Day) 1876 (Year)

7. AGE 38 Yrs. — Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Teamster
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Roberts

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alex Shushakov
(Address) 1124 Grand Ave.

15. Filed 9-25 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from dead ~~191~~ to ~~191~~, that I last ~~saw him alive~~ on Sept. 23 1914 and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Suicide Catholic Acute Poison

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Adolph Schuster M. D.

19 ..... (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — DATE OF BURIAL Sept 26 1914

20. UNDERTAKER Fry & Summers — ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9070

Registered No. 238

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

2. FULL NAME C. L. Bradford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. not obtainable (Month) (Day) (Year)

7. AGE About 46 Yrs. — Mos. — ds.

If LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ind.

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. L. Leffler

(Address) 711 Bannock St.

15. Filed 9-24 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 22 24 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Sept 22 1914, that I last saw h— alive on Sept 22 1914, and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Coma

Several Days

(Duration) Yrs. mos. ds.

Contributory (Secondary) Dropsy

(Duration yrs. 3 mos. ds.

(Signed) Geo. Peters M. D.

9-22 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill C.D. Plat. DATE OF BURIAL 9 25 1914

20. UNDERTAKER Schrader & Underwood ADDRESS Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 9071
Registered No. 237

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1909 V. 10th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick J. Kinney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. (Month) May (Day) 31 (Year) 1846
7. AGE: 68 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Stone Cutter
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: Parick Kinney
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: not obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs P J Kinney
(Address) Boise
15. Filed 9-24 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) September (Day) 23 (Year) 1914

17. I HEREBY CERTIFY, That I attended deceased from June 10 1914, to Sep 23 1914, that I last saw h[im] alive on Sep 18 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Softening of brain, Degeneration of brain following hemorrhage with coma.
(Duration) Yrs. 3 mos. ds.
Contributory (Secondary) General hemorrhage,
Hemiplegia.
(Duration) yrs. mos. ds.
(Signed) L. D. McCalla M. D.
19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 9/25 1914
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

Dr. McCalla

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 9072
Registered No. 235

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Mae Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. (Month) Not Obtainable (Day) 1 (Year)
7. AGE: Yrs. Unknown Mos. Ds. About 40 yrs. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Beauty Doctor
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Unknown
10. NAME OF FATHER: Not Obtainable
11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable
12. MAIDEN NAME OF MOTHER: Not Obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Meier
(Address) Pacific Hotel Boise
15. Filed 9—21 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Sept (Day) 20th 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1914, to Sept 20 1914, that I last saw her alive on 19 1914, and that death occured on the date stated above, at 3A M.
The CAUSE OF DEATH* was as follows:
Cardiac Dropsy
(Duration) Yrs. 9 mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) R & S Lantz M. D.
Sept 21 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Co Plot — DATE OF BURIAL: 9/24 1914
20. UNDERTAKER: Silmiba & Redington — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9073

Registered No. 237

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 7004

(No. 110 East Bannock St.)

2. FULL NAME John Rose

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Abt (Month) 1 (Day) [illegible] (Year)

7. AGE: About 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): not Obtainable

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Boise

15. Filed 9-21 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1914, to Sept 17 1914, that I last saw h— alive on 17 Sept 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

..... (Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R C Hunt M. D.

19 ..... (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Co Rd — DATE OF BURIAL: 9/21 1914

20. UNDERTAKER: Schreiber & Nicholson — ADDRESS: Boise

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9074
Registered No. 233

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. St. Alphonsus Hosp St.)
Registration District No. 2
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frankie Omer Gilman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 22 (Day) 1913 (Year)

7. AGE: ____ Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Star. Ida

10. NAME OF FATHER: M M Gilman

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Ida Corron

13. BIRTHPLACE OF MOTHER (State or Country): Idaho,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Star Idaho
(Address) M M Gilman

15. Filed 9 — 19 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1914, to Sept 19 1914, that I last saw him alive on Sept 19 1914, and that death occured on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:
Shock from Gunshot wounds
and Entrainment of Skull

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Depressed fracture of Skull
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) L. P. McCall M. D.
19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Idg — DATE OF BURIAL: Sept 20 1914
20. UNDERTAKER: Terry & Summers — ADDRESS: Boise Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9075

Registered No. 232

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St Lukes St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME R R Warren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Not Ascertained (Day) (Year) 1854

7. AGE: 60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Ascertained

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde E Summers

(Address) Boise Ida

15. Filed 9-16 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Sept (Day) 14 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1914, to Sept 14 1914, that I last saw him alive on Sept 14 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arteria Nephritis

(Duration) Yrs. mos. ds.

(Signed) M S Smith M. D.

9/15 1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ketchem Ida DATE OF BURIAL: Sept 17 1914

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9076

Registered No. 231

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St. Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Halston E. Nott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 5 (Day) 1874 (Year)

7. AGE: 40 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Lee Nott

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Westworth

(Address) South Boise Idaho

15. Filed 9-15 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 15th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1914, to Sept 15th 1914, that I last saw h alive on Sept 15th 1914, and that death occured on the date stated above, at 7 30 a M.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs
following Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Roy Baerk M. D.

Sept 15 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: Sept 16 1914

20. UNDERTAKER: Terry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1014

File No. 2077

Registered No. 238

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1116 O Harrell St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stanley Banks Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH. June (Month) 5th (Day) 1914 (Year)

7. AGE ——— Yrs. 3 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise, Idaho

10. NAME OF FATHER R. H Miller

11. BIRTHPLACE OF FATHER Mass. (State or Country)

12. MAIDEN NAME OF MOTHER Addie Stanley

13. BIRTHPLACE OF MOTHER Mo. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. H Miller

(Address) Boise, Ida.

15. Filed 9-15 1914 M S Parker Local Registrar

Dr. Allen.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 14th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/14 1914, to 9/14/ 1914, that I last saw h[illegible] alive on 9/14/ 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Convulsions

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration .....yrs.....mos.....ds.

(Signed) [illegible] M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	9/15 1914
20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1014
File No. 9078
Registered No. 229

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1214 Franklin St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Elizabeth Hubbell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.
June 23 (Month) (Day) 1840 (Year)

7. AGE
74 Yrs. 2 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) New York State

10. NAME OF FATHER
Mr. Reynolds

11. BIRTHPLACE OF FATHER
(State or Country) American

12. MAIDEN NAME OF MOTHER
Elizabeth Elliot

13. BIRTHPLACE OF MOTHER
(State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Norman S. Hubbell
(Address) Boise Idaho

15.
Filed 9-14 1914
W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1914, to Sept 13 1914, that I last saw h-- alive on Sept 13. 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Asthma

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [redacted] M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery
DATE OF BURIAL: 9/16 1914

20. UNDERTAKER: Schreiber & Siebenpfeiffer
ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9079

Registered No. 227

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1901 Ridenbaugh St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H. Howell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Oct. (Month) 28 (Day) 1834 (Year)

7. AGE: 81 Yrs. 10 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. H. Bennett

(Address) E 3403 Trent Spokane Wn.

15. Filed 9-11 1914

W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1914, to Sept 9 1914, that I last saw h[illegible] alive on Sept 9 1914 and that death occured on the date stated above, at 4.40 M.

The CAUSE OF DEATH* was as follows:

Chronic vascular kidney disease and asthma

(Duration) 19 Yrs. mos. ds.

Contributory (Secondary) Resources of above

(Duration yrs. mos. ds.

(Signed) N D Morris M D

19 (Address) 204 S Owyhee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Out yrs. mos. days. In the State 2nd yrs. mos. days

Where was disease contracted if not at place of death? Red Oak Iowa

Former or usual residence Red Oak Iowa

19. PLACE OF BURIAL OR REMOVAL: Red Oak Iowa — DATE OF BURIAL: Sept 16 1914

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9080

Registered No. 226

Registration District No. 2

Primary Registration District No. 1044

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1604 N. 20th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Alfred Bower

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 1st (Day) 1914 (Year)

7. AGE: Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: John Bower

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Dora Gattri

13. BIRTHPLACE OF MOTHER (State or Country): Tex.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Bower

(Address)

15. Filed 9-11 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 3 1914, to Sep 10 1914, that I last saw him alive on Sep 10 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Marasmus (Marasmus)

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Cardiac collapse

(Duration yrs. mos. 1 ds.

(Signed) Thomas N. Brastan M. D.

Sept 11 1914 (Address) 509 Empire Bldg. Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/11 1914

20. UNDERTAKER: Schaefer Mortuary — ADDRESS: Boise

Dr. Brackett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9081

Registered No. 225

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1054

(No. 1½ N. Front St.)

2. FULL NAME Lung Yuie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. .....(Month) .....(Day) .....1 (Year)

7. AGE: About 76 Yrs. ..... Mos. ..... Ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sing Hong

(Address) Boise

15. Filed 9-11 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from dead 9/10 1914, ~~to~~ found 191..., ~~that I last saw alive on~~ 191..., and that death occured on the date stated above, at about 12 M.

The CAUSE OF DEATH* was as follows:

No Physician was attendance
has been failing for 6 years
with Heart trouble.

~~(Duration) ... Yrs. ... mos. ... ds.~~

Contributory (Secondary) .....

~~(Duration ... yrs. ... mos. ... ds.~~

(Signed) Adolph Schreiber M.D.

19.... (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Cemetery — DATE OF BURIAL: 9/12 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9052

Registered No. 224

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 214 Luker Hos. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lung Buck Gee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 70 Years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wong Poy

(Address) Boise Idaho

15. Filed 9-10 1914 M S Parker Local Registrar

BYMB - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1914, to Sept 8 1914, that I last saw h— alive on the 8th Sept 1914 and that death occured on the date stated above, at 9.40 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (Duration) ..... Yrs. ? mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R E Sinsky M. D.

Sept 9 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Christian Cemetery | DATE OF BURIAL: 9/10 1914

20. UNDERTAKER: Schneider & Heidenfelder | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9083

Registered No. 223

Registration District No. 2

Primary Registration District No. 1005

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie C. Day

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH.

Dec. (Month) 27 (Day) 1846 (Year)

7. AGE

67 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Nathaniel Crayton

11. BIRTHPLACE OF FATHER (State or Country) American

12. MAIDEN NAME OF MOTHER Susan Snyder

13. BIRTHPLACE OF MOTHER (State or Country) Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Alta D. Shaw Boise

15.

Filed 9-10 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1914, to Sept 8 1914, that I last saw h.d alive on Sept 8 1914, and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Suppurative Cholecystitis and to gall stone

(Duration) ? Yrs. mos. ds.

Contributory (Secondary) myocarditis

(Duration yrs. mos. ds.

(Signed) M. H. Dillman M. D.

9/9 1914 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Huntington Or.

19. PLACE OF BURIAL OR REMOVAL Walla Walla Wash. DATE OF BURIAL 9/10 1914

20. UNDERTAKER Schreiber & Sidenfaden ADDRESS Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9084

Registered No. 222

1. PLACE OF DEATH.

County of Ada

City of Boise Ida

Registration District No V

Primary Registration District No 1904

(No. 1115 N. 12 St St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eleanor Perry Tarrens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Dec. (Month) 20 (Day) 1835 (Year)

7. AGE: 78 Yrs. 8 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John A. Thorpe

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. M. Perry

(Address) Boise 609 N 7th St

15. Filed 9-10 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1914, to Sept 9 1914, that I last saw her alive on Sept 9- 1914, and that death occured on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) Gastric Hemorrhage

(Duration yrs. mos. 1 ds.

(Signed) J Carl Hill M. D.

9/9 1914 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 10 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 9085
Registered No. 221

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 417 1/2 So 11th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys [redacted]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 9 (Month) (Day) 1914 (Year)

7. AGE: [illegible] Yrs. 2 Mos. [illegible] ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Ben Hallmann

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Clara [illegible] Jansen

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [illegible]
(Address) [illegible] Boise

15. Filed Sept 8 1914
M S Parker
Local Registrar

Dr. Pettinger

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occured on the date stated above, at — M.
The CAUSE OF DEATH* was as follows:

Don't Know

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) [illegible] M. D.
9/9 1914 (Address) [illegible] Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cby — DATE OF BURIAL: 9/9 1914

20. UNDERTAKER: Schreiber & Diefendorf — ADDRESS: Boise

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Boise

City of Ada.

Registration District No. 7

Primary Registration District No. 10004

(No. ....., ... St.)

File No. 9056

Registered No. 218

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Elmer Archer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 7th (Day) 1910. (Year)

7. AGE: 4 Yrs. 3 Mos. ——— ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ———

(b) General nature of industry, business, or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James E. Archer.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Elizabeth J Frank

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Archer

(Address) Boise R.R. No 2

15. Filed 9-8 1914 W. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18th 1914, to Sept. 7th 1914, that I last saw him alive on Sept 6th 1914, and that death occured on the date stated above, at 8.45 A. M.

The CAUSE OF DEATH* was as follows:

Enteros colitis - acute

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

Sept 7 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sep 8 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 219 9097

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 307 So 5th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Joseph Hanley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 13 (Day) 1901 (Year)

7. AGE: 13 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Eureka Utah

10. NAME OF FATHER D. J. Hanley

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Katherine Lynn

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Irene Hanley
(Address) 307 So. 5th St

15. Filed Sept. 7th, 1914 — M. B. Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 6 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1914, to Sept 6, 1914, that I last saw h.im alive on Sept 6 1914, and that death occured on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:
Septic pneumonia
due to burns of conjunctivitis

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) M. Hallenman M. D.

9/7 1914 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 9/7 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

SYMS - YORK CO., PTRS. & BORS. 24658

County of Ada
City of Boise

Primary Registration District No. 1004
(No. 1324 Jefferson St.)

Bureau of Vital Statistics
File No. 218 9085
Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary H. Frawley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 13, 1876. (Month) (Day) (Year)

7. AGE: 38 Yrs. about 33 Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England-Oldsbury

10. NAME OF FATHER James Wright

11. BIRTHPLACE OF FATHER (State or Country) England -

12. MAIDEN NAME OF MOTHER Rebecca Willott.

13. BIRTHPLACE OF MOTHER (State or Country) England -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward J. Frawley
(Address) Boise Idaho,

15.
Filed Sept. 7th, 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 5th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1914, to Sept 5 1914, that I last saw h.r alive on Sept 5 1914, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Burns

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) W. B. Smith M. D.

9/6 1914 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/7 1914

20. UNDERTAKER: Schreiber & Siddons — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada.

City of Boise (No. 1418 State St. St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 9089

Registered No. 217

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M. Kerr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sep 3 (Month) (Day) 1852 (Year)

7. AGE: 62 Yrs. ..... Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: John C. Kerr.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Sarah Mercer.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Blanche Kerr
(Address) .....

15. Filed 9-5 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 4th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17th 1914, to Sept 4th 1914, that I last saw h. alive on Sept 4th 1914, and that death occured on the date stated above, at 9-15 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic interstitial nephritis and acute obstruction of bowels Cathy

(Duration) a Couple of weeks Yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

Sept 5 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: 9-6 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9090

Registered No. 215

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 1004

County of Ada

City of Boise (No. 110, East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leong On

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not obtainable (Month) (Day) 1 [illegible] (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laundry worker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Ditto

13. BIRTHPLACE OF MOTHER (State or Country): Ditto

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chin Lee K.
(Address) Boise

15. Filed 9-4 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 1914, to Sept 2 1914, that I last saw h— alive on Sept 2 1914, and that death occured on the date stated above, at 5A. M.

The CAUSE OF DEATH* was as follows: Nephritis Cystitis

..... (Duration) Yrs. 5 mos. ..... ds.

Contributory (Secondary) Gonorrhea

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) R E Sturtz M. D.

19..... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chinese Cemetery	9/4 1914
20. UNDERTAKER: Schrader & Eidenfaden	ADDRESS: Boise Idaho

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1014
File No. 9091
Registered No. 214

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick Dowling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1840 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St John N. B.

10. NAME OF FATHER: Jeremiah Dowling

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frances E. Dowling
(Address) Boise

15. Filed 9-3 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 3rd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 4 A. M.
The CAUSE OF DEATH* was as follows:
Cancer of head

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Lucas M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise. Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 9/4 1914

20. UNDERTAKER: Schneider & Siddenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 9092
Registered No. 270

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 502 So 15th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Goodrich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 3rd (Day) 1826 (Year)

7. AGE: 87 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... retired Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Springfield, Mass

10. NAME OF FATHER not obtainable

11. BIRTHPLACE OF FATHER (State or Country) American

12. MAIDEN NAME OF MOTHER not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G M Goodrich
(Address) 418-80-14-12 Boise

15. Filed 9-2 1914 M S Parker Local Registrar
Dr. Smith

SVMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 2nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20th, 1914, to Sept 1 1914, that I last saw him alive on Sept 1 1914, and that death occured on the date stated above, at 2:15 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Lobar
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W B Smith M. D.
9/1 1914 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery
DATE OF BURIAL: 9/3 1914

20. UNDERTAKER: Schreiber & Siddenden
ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9093

Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2W 10
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Eilbert Payne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1866 (Year)

7. AGE: 47 yrs. 10 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Wm. G. Payne

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): P P Blair
(Address):

15.
Filed Nov 5 1914. J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1914, to Sept 30 1914, that I last saw him alive on Sept 30 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Peritonitis - Probably due to a perforated gastric Ulcer -
(Duration) yrs. mos. one ds.
Contributory (Secondary): Ulcer of stomach ?
(Duration) yrs. mos. ds.

(Signed) P. B. Cunningham M. D.
Oct 22 1914 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: Oct 2 1914

20. UNDERTAKER: C. T. Smith
ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 210 File No. 9095

County of ..... Primary Registration District No. .....

City of ..... (No. ....., ... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John T. Sanders

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1853 (Year)

7. AGE: 60 yrs. 11 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed 10-14 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1914, to Oct 1st 1914 that I last saw h[illegible] alive on Sept 30 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Dilitation of Heart.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. O. Clark M. D.

19..... (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery — DATE OF BURIAL: Oct 3 1914

20. UNDERTAKER: C. D. Buckner — ADDRESS: Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9096

Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2260
Primary Registration District No. 1010
(No. , St.)

2. FULL NAME William F. Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Oct (Month) 24 (Day) 1890 (Year)

7. AGE: 23 yrs. 11 mos. 5 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John Smith

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Christina Bott

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): [illegible]
(Address): Emmett Idaho

15.
Filed 12-4, 1914 J. A. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1914., to Sept 28 1914 that I last saw h[illegible] alive on Sept 28 1914., and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia, Acute
(Duration) yrs. mos. 10 ds.
Contributory (Secondary): Dilitation of heart
(Duration) yrs. mos. ds.
(Signed) J. A. Reynolds M. D.
9-27 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery
DATE OF BURIAL: Sept 30 1914

20. UNDERTAKER: C. D. Buckner
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)

Registration District No. 52
Primary Registration District No. 2136
File No. 9097
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances Welch

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 3 (Day) 1889 (Year)

7. AGE: 25 yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Wardboro Conn

10. NAME OF FATHER: Wm Bridges

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Frances Bridges

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles E Welch
(Address) Wardboro Ida

15. Filed 9/25 1914 by E. F. Gregory M.D. Asst Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1914, to Sept 23 1914, that I last saw her alive on Sept 23 1914 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Scarlet fever

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo F Cooley M. D.
Sept 23 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wardboro Ida
DATE OF BURIAL: 9/25 1914

20. UNDERTAKER: Owen
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17143

Form V. S. No. 5 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9095
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)

Registration District No. 59
Primary Registration District No. 2136

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ruby Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 8 (Day) 1914 (Year)

7. AGE: 1 yrs. 11 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montpelier

10. NAME OF FATHER: W W Clark Jr

11. BIRTHPLACE OF FATHER (State or Country): Geo Town

12. MAIDEN NAME OF MOTHER: Ethel Cook

13. BIRTHPLACE OF MOTHER (State or Country): Juneau

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Dr Buckley
(Address): Montpelier

15. Filed 10/8/1914 H H Ring Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1914, to Oct 8 1914
that I last saw he alive on Oct 8 1914
and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 1 yrs. ..... mos. ..... ds.
Contributory Scarlet Fever
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Buckley M. D.
Oct 8 1914 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 11 mos. 17 ds. In the State 1 yrs. 11 mos. 17 ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL, OR REMOVAL: Montpelier
DATE OF BURIAL: 10/8/1914

20. UNDERTAKER: None.
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 85

Primary Registration District No. 7136

File No. 9099

Registered No.

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Aaron Cornford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Dec 10th 1907 (Month) (Day) (Year)

7. AGE: 6 yrs. 9 mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George J. Cornford

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Christina Buckley.

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A H Hoff

(Address) Montpelier

15. Filed 10/10/1914 W H King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 9th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h[illegible] alive on Oct 9th 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D W Poyeler M. D.

10-10 1914 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. 9 mos. days. In the State 6 yrs. 9 mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier | DATE OF BURIAL: 10/10/1914

20. UNDERTAKER: None | ADDRESS

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2,136
(No. ....., ... St.)

File No. 9100
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeanette Tippets

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
Mar. 15 Th 1844
(Month) (Day) (Year)

7. AGE
70 yrs. 7 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER William Tippets

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Sophia Meade

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin Winters
(Address) Montpelier, Idaho

15. Filed 10/14/1914 N. N. King M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct 13 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1914, to Oct 3 1914, that I last saw her alive on Oct 3 1914, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows: Senile Decay (Uremia)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dow Poyneer M. D.
10/14 1914 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 30 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Missouri

19. PLACE OF BURIAL OR REMOVAL Georgetown Ida — DATE OF BURIAL 10/14/1914

20. UNDERTAKER None — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

County of [redacted] Primary Registration District No. [redacted] File No. [redacted]

City of Manfield (No. [redacted] St.) Registered No. [redacted]

If death occurs away from final residence, give facts called for under special information.

2. FULL NAME Ellen Mc Cook

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: January (Month) 28 (Day) 1900 (Year)

7. AGE: 9 yrs. 9 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Dingle Bear Lake Co Ida.

10. NAME OF FATHER Geo. Cook

11. BIRTHPLACE OF FATHER (State or Country) Cedar Fort Utah

12. MAIDEN NAME OF MOTHER Elizabeth Nate

13. BIRTHPLACE OF MOTHER (State or Country) Lehi Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Cook
(Address) Dingle Ida.

15. Filed 10/16/1914 H. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1914, to Oct 16 1914, that I last saw h[illegible] alive on Oct 16 1914, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Scarlet fever

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 16 1914 (Address) Manfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 9 yrs. 9 mos. 19 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dingle Ida

DATE OF BURIAL: 10/16/1914

20. UNDERTAKER: —

ADDRESS

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 9103
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chloe Winters

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January (Month) 8th (Day) 1876 (Year)

7. AGE: 38 yrs. 10 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Brigham L. Tippets

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Abigail E. Tippets

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin Winters
(Address) Montpelier

15. Filed 11/5/1914 N H King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-2- 1914, to 11-3- 1914, that I last saw her alive on Nov 3 1914, and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Labor.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Don Poynter M. D.
11/3 1914 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. ..... mos. ..... days. In the State 34 yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida
DATE OF BURIAL: 11/5/1914

20. UNDERTAKER: None
ADDRESS: —

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of American Falls (No. Bethany Deaconess Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116
Primary Registration District No. 2195

File No. 8104
Registered No. 23
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Dick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ~~Sept~~ Sept 23 1891
(Month) (Day) (Year)

7. AGE: 23 yrs. 0 mos. 23 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Herman Giesbrecht

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Tabert

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. B. Dick
(Address)

15. Filed Oct 18 1914 Mennett Klein Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 16 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1914, to Oct 13 1914, that I last saw h[illegible] alive on Oct 13 1914 and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:
Appendicitis -
Operated on Oct 13 1914

(Duration) yrs. 4 mos. - ds.
Contributory Uraemia
(Secondary)
(Duration) yrs. mos. 2 ds.

(Signed) M. Klein M. D.
Oct 18 1914 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death - yrs. - mos. 4 days. In the State 7 yrs. - mos. - days.
Where was disease contracted if not at place of death? At Aberdeen Ida
Former or usual residence Aberdee

19. PLACE OF BURIAL OR REMOVAL: Mennonite Cemetery — DATE OF BURIAL: Oct 19 1914
20. UNDERTAKER: Wells Pickel — ADDRESS: Aberdee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl

Registration District No. 39.
Primary Registration District No. 2087.
(No. ....., ... St.)

File No. 9105
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Grace Ellen Lowry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Oct. 17 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Buhl Idaho

10. NAME OF FATHER: Walter D. Lowry

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Alice M. Hance

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. D. Lowry
(Address) Buhl Idaho

15. Filed 10-21 1914 J. T. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17 1914, to Oct 20 1914 that I last saw him alive on Oct. 19 1914 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Found dead in bed
Cause unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Wilhelm M. D.
Oct 21 1914 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl
DATE OF BURIAL: 10-22 1914

20. UNDERTAKER: Keen
ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Cambridge

Registration District No. 87
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 9106
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesther Dudley Brown

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 18 (Day) 1857 (Year)

7. AGE: 57 yrs. 1 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Prop.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Murray Fuld Ill

10. NAME OF FATHER: Rhaben M Brown

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Jane Mac (Elizabeth)

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Brown
(Address) Cambridge Ida

15.
Filed Sept 23 1914 — O E Schuntz, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1914, to Sept 23 1914
that I last saw h[illegible] alive on Sept 18 1914
and that death occurred on the date stated above, at 8 PM.

The CAUSE OF DEATH* was as follows:
Paralysis of Bowels
..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Cachexia
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Schuntz M. D.
Sept 23 1914 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley
DATE OF BURIAL: Sept 24 1914
20. UNDERTAKER: J W Gudelson
ADDRESS: Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 1916 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 85
County of Washington Primary Registration District No. 2164
City of Salubria (No. ....., ... St.)
File No. 910
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Vonturus Hannan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1849 (Year)

7. AGE: 65 yrs. 5 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: John Hannan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Catherine Conly

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nancy Hannan
(Address) Salubria

15. Filed Oct 24 1914 O E Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1914, to Oct 21 1914
that I last saw he died alive on Oct 21 1914
and that death occurred on the date stated above, at 9 AM.

The CAUSE OF DEATH* was as follows:
Nephrites uremia Dave Salient contd after death rigid rupt unconscious
Jno D. O E Schmuck
(Duration) 1 yrs. ..... mos. ..... ds.
Contributory Boozing
(Secondary)
(Duration) 24 yrs. ..... mos. ..... ds.
(Signed)* Dr S Hopper M. D.
Oct 24 1914 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salubria Idaho
DATE OF BURIAL: Oct 25 1914

20. UNDERTAKER: J R Anderson
ADDRESS: Cambridge Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9108
Registered No.

1. PLACE OF DEATH. Registration District No. 88
County of Washington Primary Registration District No. 2164
City of Cambridge (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B Allison

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 28 (Day) 1843 (Year)

7. AGE: 69 yrs. 1 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Alexander Allison

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: M. Glover

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex Allison
(Address) Cambridge

15.
Filed Oct 5 1914 O E Schmuntz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1914, to Oct 1 1914
that I last saw him alive on Oct 1 1914
and that death occurred on the date stated above, at 9 45 M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach and bowels

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Hereditary influence

..... (Duration) 5 yrs. 2 mos. 20 ds.

(Signed) O E Schmuntz M. D.
Oct 4 1914 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell — DATE OF BURIAL: Oct 5 1914

20. UNDERTAKER: Jos Needelman — ADDRESS: Cambridge Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9109
Registered No.

1. PLACE OF DEATH.
County of
City of
Registration District No. 87
Primary Registration District No. 2164
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Carroll

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH
(Month) (Day) 1836 (Year)

7. AGE: 82 yrs. mos. ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): X

10. NAME OF FATHER: X

11. BIRTHPLACE OF FATHER (State or Country): X

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A K Asby
(Address) Cambridge Idaho

15. Filed Oct 3 1914 O E Schwartz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191
that I last saw h alive on 191
and that death occurred on the date stated above, at 6.25 a.m.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) yrs. 5 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Lemuel Hopkins M. D.
Oct 3 1914 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 9 mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho
DATE OF BURIAL: Oct 3 1914

20. UNDERTAKER: Jos Needleman
ADDRESS: Cambridge

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9110

Registered No.

1. PLACE OF DEATH. Registration District No. 88

County of Washington Primary Registration District No. 2164

City of Cambridge (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Baby Beck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct 1 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cambridge Ida

10. NAME OF FATHER: Wm A Beck

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Lula Binkley

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W A Beck
(Address) Cambridge Ida

15. Filed Oct 5 1914 C E Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 4 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Oct 4 1914 that I last saw h alive on Oct 1 1914 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from base of cord

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hobbes M. D.

Oct 5 1914 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho

DATE OF BURIAL: Oct 4 1914

20. UNDERTAKER: Jos Hedelsun

ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

Primary Registration District No. 2177

File No. 911

County of Fremont

City of St Anthony (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Robb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Oct (Month) 14 (Day) 1851 (Year)

7. AGE: 62 yrs. 11 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sidney Australia

10. NAME OF FATHER William Robb

11. BIRTHPLACE OF FATHER (State or Country) Aberdeen Scotland

12. MAIDEN NAME OF MOTHER Ellen Bell

13. BIRTHPLACE OF MOTHER (State or Country) Aberdeen Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M Robb

(Address) Camp on Creek

15.

Filed Oct 9th 1914 W. Rivers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1914, to Sept 27 1914, that I last saw him alive on Sept 27 1914, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Gangrene of Pelvis + Septicemia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory Fracture of Pelvis
(Secondary)

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) A Morsfelder M. D.

Sept 29 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 ..... days. In the State Ida yrs 62 mos 2 days.

Where was disease contracted if not at place of death? .....

Former or usual residence Nelson Ida

19. PLACE OF BURIAL OR REMOVAL: Nelson Cemetery

DATE OF BURIAL: Oct 1st 1914

20. UNDERTAKER: Wd Mayer

ADDRESS: St Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9112

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No 99

Primary Registration District No 2177

(No. ....., ... St.)

2. FULL NAME Lillian Coolidge Woodman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 1st (Day) 1879 (Year)

7. AGE: 35 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER Charles Parbell

11. BIRTHPLACE OF FATHER (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Mary Eskridge

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Boucher

(Address) St. Anthony

15. Filed Nov 9th 1914 W D Wright Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1913, to Nov 8 1914, that I last saw her alive on Nov 7 1914, and that death occured on the date stated above, at 9.05a M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 Yrs. 0 mos. 0 ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) J. E. Boucher M. D.

8/9 1914 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls — DATE OF BURIAL: Nov 10 1914

20. UNDERTAKER: W. D. Gage — ADDRESS: St Anthony

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

File No. 912

County of Fremont

Primary Registration District No. 2177

Registered No.

City of Parker (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Adeline Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Nov (Month) 27 (Day) 1853 (Year)

7. AGE: 60 yrs. 11 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake Utah

10. NAME OF FATHER: Alvin Montieth

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Hariet Crago

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H Jackson

(Address) Parker Ida

15. Filed Nov 9 th 1914 W Burk Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1914, to Nov 6 1914, that I last saw her alive on Nov 6 1914, and that death occurred on the date stated above, at 3 30 M.

The CAUSE OF DEATH* was as follows:

Acute Cerebritis

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Cerebral Sclerosis & Coma

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) A. Morefield M. D.

Nov 7 1914, (Address) Plaintiff Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker — DATE OF BURIAL: Nov 8 1914

20. UNDERTAKER: None — ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

Primary Registration District No. 2177

File No. 9114

County of Fremont

City of Teton (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Billie Howes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH

April (Month) 4 (Day) 1913 (Year)

7. AGE

1 yrs. 6 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sugar Idaho

10. NAME OF FATHER Culbert Roy Howes

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Leah Huggard

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Culbert R. Howes

(Address) Teton Ida.

15. Filed Nov 9th 191X

W. D. Wright X
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov (Month) 3 (Day) 191X (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 191X, to Nov 3 191X, that I last saw her alive on Nov 3 191X, and that death occurred on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Morgan M. D.

Nov 3 191X, (Address) St Anthony Ida,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton

DATE OF BURIAL: Nov 4 191X

20. UNDERTAKER: none

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
(No. .... St.)

File No. 915
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont
City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ——— Battson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): infant

6. DATE OF BIRTH. Nov (Month) 4 (Day) 1914 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Anthony Ida

10. NAME OF FATHER Edwin Battson

11. BIRTHPLACE OF FATHER (State or Gountry) Mississouri

12. MAIDEN NAME OF MOTHER Leah Arilla Smith

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Boucher M.D.
(Address) St. Anthony

15. Filed Nov. 9 1914 W. Bell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1914, to Nov 4 1914, that I last saw him alive on Nov 4 1914, and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows: birth Premature infant

(Duration) 0 Yrs. 0 mos. 0 ds.
Contributory (Secondary) —
(Duration — yrs. — mos. ..... ds.
(Signed) J. E. Boucher M. D.
11/5 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER None | ADDRESS —

SYMS - YORK CO., PTRS. & BOBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

File No. 9116

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andy Brotherson Chipman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 01 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): St Anthony

10. NAME OF FATHER: Andy Chipman

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Clementine Brotherson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andy Chipman
(Address) St Anthony Ida.

15. Filed Nov 9 1914 W Beard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) ..... (Day) 191.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1914, to Sept 19 1914, that I last saw h (illegible) alive on Sept 19 1914 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Icterus Neonatorum.

..... (Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) Premature Delivery

..... (Duration) ..... yrs. ..... mos. 15 ds.

(Signed) J Morfield M. D.

Sept 19 1914 (Address) St Anthony.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony Idaho — DATE OF BURIAL: Sept 20 1914

20. UNDERTAKER: None — ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

Primary Registration District No. 2177

File No. 911

County of Fremont

City of St Anthony. (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carolina [redacted] Partsch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: June (Month) 14 (Day) 1831 (Year)

7. AGE: 83 yrs. 3 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Mr Partsch

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Fila
(Address) St Anthony

15. Filed Nov 10 191[illegible] Lola W Devin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 7 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from none, 191[illegible], to none, 191..., that I last saw h[illegible] dead alive on Sept 7 191[illegible] and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Cardiac Failure

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) Senility

(Duration) several yrs. ... mos. ... ds.

(Signed) J Mortfield M. D.

19... (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: St Anthony Oda — DATE OF BURIAL: Sept 11 191[illegible]

20. UNDERTAKER: none — ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of St Anthony, or R.F.D.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)

File No. 9118
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Geo E Dennick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1860 (Year)

7. AGE: 53 yrs. 9 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Retired farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Henry County Ill.

10. NAME OF FATHER: Chancey Dennick

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Lambert

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Dennick
(Address) Osceola Nebr.

15. Filed July 11 1914 — W Dewrst, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about time 191..., to ..... 191.....
that I last saw him alive on ..... 191....,
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Probably Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Dewrst M. D.
7 11 1914 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Osceola Nebraska
DATE OF BURIAL: Not Known 1914

20. UNDERTAKER: W D Hyer
ADDRESS: St Anthony Ida

EYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 17
File No. 919
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Parker
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lester Jenkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Oct (Month) 28 (Day) 1896 (Year)

7. AGE
17 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Parker Idaho

10. NAME OF FATHER: Henry E Jenkins

11. BIRTHPLACE OF FATHER (State or Country): Council Bluffs Iowa

12. MAIDEN NAME OF MOTHER: Elizabeth Rice

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W Everett
(Address) St Anthony Ida

15.
Filed Nov 9th 1914 W Everett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 2nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5th 1914, to Oct 2nd 1914, that I last saw h[illegible] alive on Oct 2nd 1914 and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Peritonitis from Perforation of Bowel
(Duration) ..... Yrs. mos. 3 ds.
Contributory (Secondary) typhoid fever
(Duration) ..... yrs. mos. 28 ds.
(Signed) W Everett M D
19..... (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker Ida — DATE OF BURIAL: Oct 4 1914

20. UNDERTAKER: None — ADDRESS: None

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 93
Primary Registration District No. 2171
File No. 9120
Registered No. .....

1. PLACE OF DEATH.
County of Nez Perces
City of Peck
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Etta A. Ricketts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1883 (Year)

7. AGE: 30 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Marion W. Ricketts

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Anna Puckett

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M W Ricketts
(Address) Peck

15. Filed Oct. 8 1914 — J. M. Lyle, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1909, to Sept. 1914, that I last saw her alive on Sept. 11 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Lyle M. D.
10-8 1914 (Address) Peck

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Central Ridge — DATE OF BURIAL: Oct. 7 1914

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 9123
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Kamiah (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Yellow Bear
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Indian	Widowed

6. DATE OF BIRTH
Don't know 1
(Month) (Day) (Year)

7. AGE
About 100 years. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Don't know

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hattie Enos
(Address) Kamiah Ida.

15.
Filed 10/13 1914 W. T. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
10 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not at all 191..., to ..... 191...,
that I last saw h— alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Probably old age
No physician in attendance.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. McMahan M. D.
10/17 1914 (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indenen Cemetery | DATE OF BURIAL: Oct 13 1914

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 9122
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Kamiah (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Powers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Dont Know (Month) 1 (Day) (Year)

7. AGE: about 95 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: dont Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Camille Williams
(Address) Kamiah Idaho

15. Filed 10/12 1914 W. F. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not at all 191 , to 191 , that I last saw h alive on 191 , and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Probably old age. (No physician was in attendance)

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. F. McMahan M. D.
10/10 1914 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Private Cemetery
DATE OF BURIAL: 10/12 1914

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No.
Registered No. 9125

1. PLACE OF DEATH.
County of Idaho
City of Kamiah (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Hayes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: May 4 (Month) (Day) 1895 (Year)

7. AGE: 19 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: house keeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kamiah

10. NAME OF FATHER: James Hayes.

11. BIRTHPLACE OF FATHER (State or Country): Kamiah

12. MAIDEN NAME OF MOTHER: Fanny Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Kamiah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Hayes
(Address) Kamiah, Ida.

15.
Filed 10/10 1914 W. H. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 3 1914, to oct 10 1914 that I last saw her alive on Sept 27 1914 and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(Duration) ont known yrs. mos. ds.

Contributory (Secondary) 0

(Duration) yrs. mos. ds.

(Signed) G B Stocklin M. D.
10/12 1914 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Cem No. 1 | DATE OF BURIAL: 10/11 1914

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9124

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Tensed, Ida

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter August Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. January (Month) 5th (Day) 1880 (Year)

7. AGE: 63 Yrs. 9 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ullvetterns Augen Sweden

10. NAME OF FATHER Peter Henderson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Sara Lisa Esson

13. BIRTHPLACE OF MOTHER (State or Country) Dont Konow

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Iona Mabel Hendricks

(Address) Tensed, Idaho

15.

Filed Oct 15 1914

John Fort, Asst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1914, to Oct 14 1914, that I last saw him alive on Oct 10 1914, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Tuberculosis

(Duration 1 yrs. — mos. — ds.

(Signed) T. R. Gaylord M. D.

10/14 19 14 (Address) Deweet, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Tekoa, Wash.

DATE OF BURIAL: Oct. 16 1914

20. UNDERTAKER: C L Schuderud

ADDRESS: Tekoa, Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Desmet

Registration District No. 31

Primary Registration District No.

(No. ....., ... St.)

File No. 9125

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louise Aripa

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 5 (Day) 1914 (Year)

7. AGE: .....Yrs. 5 Mos. 1 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Desmet

10. NAME OF FATHER Stanislaus Aripa

11. BIRTHPLACE OF FATHER (State or Country) Reservation

12. MAIDEN NAME OF MOTHER Emma

13. BIRTHPLACE OF MOTHER (State or Country) Spokane Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaus Aripsa

(Address) Desmet, Idaho

15.

Filed Oct 7 1914

Geo. J. Kugler
Local Registrar
per John Post

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1914, to Oct 6 1914, that I last saw her alive on Oct 6 1914, and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) .....Yrs. .....mos. 7 ds.

Contributory (Secondary) none

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. R. Ballard M. D.

Oct 7 1914 (Address) Desmet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Desmet, Idaho — DATE OF BURIAL: Oct 7 1914

20. UNDERTAKER Hetino — ADDRESS Desmet, Ida

John Post

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9126

Registered No. .....

1. PLACE OF DEATH.

County of .....

City of .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar Kaape

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) Not known (Day) 1 (Year)

7. AGE: About 45 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Policeman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Gladstead, Mont

10. NAME OF FATHER: Chas. Kaape

11. BIRTHPLACE OF FATHER (State or Country) Nash.

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Mullen

(Address) Dubois, Idaho

15. Filed Oct. 31 1914

Geo. J. Ziegler
Local Registrar
per John Post

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Homicide or murder

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Callard M. D.

10/31 1914 (Address) Dubois, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho — DATE OF BURIAL: Oct 31 1914

20. UNDERTAKER: none — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

Idaho

WASHINGTON STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 912

File No.

Registered No.

PLACE OF DEATH

County of Kootenai

City or Town of

Registration Dist. No. (No. , St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

Full Name Unnamed Armstrong

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): —

6 DATE OF BIRTH: June 27, 1914 (Month) (Day) (Year)

7 AGE: yrs. 3 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Idaho

PARENTS

10 NAME OF FATHER: Wm Armstrong

11 BIRTHPLACE OF FATHER (State or country): Mo.

12 MAIDEN NAME OF MOTHER: Frankie Sims

13 BIRTHPLACE OF MOTHER (State or country): Idaho

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. Armstrong

(Address) Tekoa Wash

15 Filed Oct. 11, 1914 John Foat, Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 10 (Month) 10 (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191...., to....., 191....,
that I last saw h..... alive on....., 191....,
and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH * was as follows:

Ns Physician attended
This baby - was present
at its birth was born & lived
just one 24 hours after
Cyanosis (Duration) 0 yrs. 0 mos. 0 ds.
Contributory (SECONDARY) was never well
nourished
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Knapp, M. D.

1914 (Address) Tekoa Wash

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Tekoa Wn — DATE OF BURIAL: 13-10. 1914

20 UNDERTAKER: C. A. Schubert — ADDRESS: Tekoa Wn

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Blaine.

City of Near Bellevue.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. 2072

(No. ....., ... St.)

File No. 912

Registered No. 20

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Glaso

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: Wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: June — 1848.
(Month) (Day) (Year)

7. AGE: 86 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ~~Scotland~~ Ireland.

10. NAME OF FATHER: H. Glaso.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: May Gardner.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel Reardon
(Address) Valley.

15.
Filed Oct 22 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. Thurston Hatch M. D.
Oct 22 1914 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Bellevue Idaho. DATE OF BURIAL: Oct 22 1914

20. UNDERTAKER: P. O. Harris ADDRESS: Hailey Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2072
File No. 9129
Registered No. 22

1. PLACE OF DEATH.
County of Boone
City of Galena
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melford Leslie Lancaster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Wht	Single

6. DATE OF BIRTH
July (Month) 16 (Day) 1892 (Year)

7. AGE
22 yrs. 4 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Colorado

10. NAME OF FATHER W E. Lancaster

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Alice L Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W E Lancaster
(Address) Filer Idaho

15. Filed Oct 20 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
October (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
Oct 20 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Filer Idaho | DATE OF BURIAL ..... 191...

20. UNDERTAKER Ralph L Harris | ADDRESS Hailey Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2077
File No. 9130
Registered No. 21

1. PLACE OF DEATH.
County of Blaine
City of Kelchum (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John McCoy

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kelchum

10. NAME OF FATHER: Melvin McCoy

11. BIRTHPLACE OF FATHER (State or Country): Kelchum

12. MAIDEN NAME OF MOTHER: Margaret Daly

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Melvin McCoy
(Address) Kelchum

15. Filed Nov 2 1914 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 191[illegible], to [illegible] 191[illegible], that I last saw him alive on Oct 28 1914 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Do not know cause or did not see baby after it was born.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Coad M. D.
Nov 7 1914 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kelchum Ida — DATE OF BURIAL: Nov 1 1914

20. UNDERTAKER: R. L. Harris — ADDRESS: Hailey Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 9131
Registered No. 23

1. PLACE OF DEATH.
County of Elmore
City of Mtn. Home (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfred Hudson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Divorced

6. DATE OF BIRTH
6 (Month) 29th (Day) 1853 (Year)

7. AGE
61 yrs. 3 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Stone Cutter
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Macclesfield Eng.

10. NAME OF FATHER Alfred Hudson

11. BIRTHPLACE OF FATHER (State or Country) Bradford Yorkshire Eng.

12. MAIDEN NAME OF MOTHER Elizabeth Smedley

13. BIRTHPLACE OF MOTHER (State or Country) Macclesfield Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. Hudson Duluth Minn
(Address) 1536 West Superior St.

15.
Filed Oct. 17th 1914 B. W. Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7th 1914, to Oct. 16th 1914, that I last saw h. alive on Oct. 16th 1914, and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:
Aortic stenosis - myocarditis

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. W. Walker M. D.
10/17 1914 (Address) Mtn. Home

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Duluth, Minn	Oct. 1914

20. UNDERTAKER	ADDRESS
H. D. Wilbur	Mtn. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19768

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020

File No. 9132
Registered No. 24
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Anna McLaughlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: March (Month) 29 (Day) 1913 (Year)

7. AGE: 1 yrs. 6 mos. 21 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Daniel McLaughlin

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary C Ryan

13. BIRTHPLACE OF MOTHER (State or Country): Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W L Frazier
(Address) Mtn Home Ida

15. Filed Oct 19th 1914 BWMather Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1914, to Oct 18 1914, that I last saw her alive on Oct 18 1914, and that death occurred on the date stated above, at 7:25 P M.

The CAUSE OF DEATH* was as follows:
Diphtheria, Scarlet Fever, and Bronchial Pneumonia
(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W L Frazier M. D.
Oct 19 1914 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home
DATE OF BURIAL: Oct 19 1914

20. UNDERTAKER: J M Gowen
ADDRESS: Mtn Home

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 9133
Registered No. 65

1. PLACE OF DEATH.
County of Canyon
City of Caldwell. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joshua C. Cassey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) ..... (Day) 1837 (Year)

7. AGE: 77 Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Julia F. Cassey
(Address) Caldwell, Ida.

15. Filed 11-2-1914 Jos. S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1914, to ..... 191..., that I last saw him alive on Oct 29 1914 and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Cardiac Asthma

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Mullen M. D.
Nov 1 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 11/2 1914

20. UNDERTAKER: W. C. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 9134
Registered No. 64

1. PLACE OF DEATH.
County of Canyon
City Caldwell (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Virginia Ray Murray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 17 (Day) 1913 (Year)

7. AGE: 1 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Benjamin F. Murray

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Emma Rodenbarger

13. BIRTHPLACE OF MOTHER (State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B. F. Murray
(Address) Caldwell Ida.

15. Filed 11-2- 1914 John D. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..... 191 ..... to ..... 191 ....., ~~that I last saw him alive on ..... 191 .....~~, ~~and that~~ death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Cause Unknown
Physician in attendance refuse to certify as to
Cause (Duration) Death Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. H. Robinson Coroner M. D.
11-2-1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 11/2 1914

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 915
Registered No. 8

1. PLACE OF DEATH.
County of Latah
City of Yale
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henrietta Franklin
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Oct. 5, 1914 (Month) (Day) (Year)

7. AGE: 0 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many ..13.. hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: James L. Franklin

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Myrtle Bennett

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. C. Faust
(Address) Deary

15.
Filed 10/7 1914 P. C. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 191..., to ..... 191..., that I last saw her alive on Oct 5. 1914 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Premature delivery.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. C. Faust M. D.
10/7 1914 (Address) P. C. Faust.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Yale
DATE OF BURIAL: Oct. 7 1914

20. UNDERTAKER: none
ADDRESS:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19750

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

Registration District No. 2147

Primary Registration District No. 07

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 913
Registered No. 10

1. PLACE OF DEATH.
County of Latah
City of Troy (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Hoidal

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Feb. 4 (Month) (Day) 1840 (Year)

7. AGE: 74 yrs. 8 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Andus Hoidal

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Anna Margreta Pedersdatter

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. C. Hoidal
(Address) Troy, Ida.

15. Filed Oct 9 1914 P. O. Hansel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 8 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1914, to Sept-30 1914
that I last saw him alive on Sept-14 1914
and that death occurred on the date stated above, at 10a.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 4 yrs. — mos. — ds.

Contributory (Secondary) Oedema of Lungs

(Duration) — yrs. — mos. 10 ds.

(Signed) Jno. E. Call M. D.

Oct. 8 1914 (Address) Troy Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Zion Cemetery
DATE OF BURIAL: Oct 11 1914

20. UNDERTAKER: V
ADDRESS: V

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 2119

File No. 9135

City of Preston (No. ....., ... St.)

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loyal Haglund

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (*Write* the word.)

6. DATE OF BIRTH: Sep. (Month) 24 (Day) 1913 (Year)

7. AGE: 1 yrs. mos. 15 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Franklin Co.

10. NAME OF FATHER: Olof Haglund

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Emily A Sharp

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Olof Haglund
(Address) .....

15. Filed Nov. 9 1914 Allen R Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 9th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1914, to Oct 9th, 1914, that I last saw him alive on Oct 9th, 1914, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Parkinson M. D.

19 .... (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston | DATE OF BURIAL: Oct 10 1914

20. UNDERTAKER: N. C. Gridmore | ADDRESS: Preston

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-23 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Franklin
City of Fairview
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 9139
Registered No. 50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ariel David Egbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 15 (Day) 1913 (Year)

7. AGE: ..... Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Fairview

10. NAME OF FATHER David W. Egbert

11. BIRTHPLACE OF FATHER (State or Country) Fairview

12. MAIDEN NAME OF MOTHER Leulla H. Bodily

13. BIRTHPLACE OF MOTHER (State or Country) Fairview

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jane Bodily
(Address) .....

15. Filed Oct. 27 1914 — Dr Allen R Carter, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 24 1914, to Oct. 26 1914, that I last saw h[illegible] alive on Oct. 24 1914, and that death occured on the date stated above, at 2- A. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of bowel.
And thereby obstructing the bowel.
(Duration) ..... Yrs. ..... mos. 16 ds.
Contributory (Secondary) Diarrhoea
(Duration) ..... yrs. ..... mos. 7 ds.
(Signed) Allen R Carter M. D.
10/27 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL: Oct. 27 1914

20. UNDERTAKER: No Undertaker — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 9140
Registered No. 51
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Clayton Packer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Sep (Month) 23 (Day) 1914 (Year)

7. AGE: X yrs. 1 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER S. D. Packer

11. BIRTHPLACE OF FATHER (State or Country) Deep Creek Onida Co

12. MAIDEN NAME OF MOTHER Ellen Rebecca Clayton

13. BIRTHPLACE OF MOTHER (State or Country) Franklin Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. D. Packer
(Address) Preston Ida

15.
Filed NOV 9 1914 W. Allen Riddle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1914, to Oct 25 1914, that I last saw h[illegible] alive on Oct 25 1914 and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

(Duration) 2 yrs. 2 mos. 8 ds.

Contributory (Secondary) 2

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Slates M. D.
Oct 26 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: Oct 26 1914

20. UNDERTAKER: W. A. Smidmore
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ....., ... St.)

File No. 9111

Registered No. 52

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marriner Victor McNeil

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Aug (Month) 14 (Day) 1914 (Year)

7. AGE

— yrs. 2 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Marriner W McNeil

11. BIRTHPLACE OF FATHER (State or Country) New Mexic

12. MAIDEN NAME OF MOTHER Lucy E. Cafferty

13. BIRTHPLACE OF MOTHER (State or Country) Fairview Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marriner W. McNeil

(Address) Preston Ida.

15.

Filed Nov. 9 1914 Dr Allen R Budge Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1914, to Oct 15 1914, that I last saw h.... alive on Oct 15 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ✓ yrs. ✓ mos. 09 ds.

Contributory (Secondary) ✓

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. L. C. Slater M. D.

Oct 15 1914. (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview Idaho | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: W. C. Skidmore | ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 91[illegible]
Registered No. 53
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Izora Thomas

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 18 (Day) 1869 (Year)

7. AGE: 44 yrs. 8 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John Dobbs

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Sorah Sisk

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel P Thomas
(Address) Preston Idaho.

15.
Filed Nov. 9 1914 Dr Allen R Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Oct. 1914, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen R Cutler M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: Oct. 17 1914

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9143
Registered No. 54

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Preston (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doral Bodily

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 1 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Afton Wyoming

10. NAME OF FATHER: Henry J Bodily

11. BIRTHPLACE OF FATHER (State or Country): Fairview Idaho

12. MAIDEN NAME OF MOTHER: Eva May Crockett

13. BIRTHPLACE OF MOTHER (State or Country): Hyde Park Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry J Bodily
(Address) .....

15.
Filed Nov. 9 1914 Dr Allen R Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1914, to Oct. 26 1914 that I last saw him alive on Oct 26 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia and Exhaustion.

..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Pneumonia bronchial 7 mos.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Allen R Curtis M. D.
..... 19..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: Oct. 27 1914

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9144

Registered No. 55

1. PLACE OF DEATH.
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Homer Campbell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Color
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Sept. (Month) 3 (Day) 1[illegible] (Year)

7. AGE: ..... yrs. 1 mos. 23 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Preston Idaho

10. NAME OF FATHER: Martin H Campbell

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Rita Porter

13. BIRTHPLACE OF MOTHER (State or Country): Provo Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin H Campbell
(Address) .....

15. Filed Nov 9 1914 Dr Allen Rutter Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1914, to Oct 26 1914
that I last saw him alive on Oct. 1 1914
and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
.....
.....
..... (Duration) ..... yrs. ..... mos. 4 ds.
Contributory None
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen Rutter M. D.
..... 19..... (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston, Ida
DATE OF BURIAL: Oct. 27 1914

20. UNDERTAKER: W. A. Lindmore
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25-M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

Primary Registration District No. 2119

File No. 9145

Registered No. 57

County of Franklin

City of Weston, Ida (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wanda Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 9 (Month) 20 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Rasmus Jensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Anna S Merck

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rasmus Jensen

(Address) Weston, Ida

15. Filed Nov. 9 1914 ..... Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/20 1914, to Sept 1st 1914, that I last saw h. 21 alive on 7/30 1914, and that death occured on the date stated above, at 11.45 P M.

The CAUSE OF DEATH* was as follows:

Inanition.

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. W. Leuck M. D.

19..... (Address) Weston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston Ida — DATE OF BURIAL: 10/3 1914

20. UNDERTAKER: Hansen — ADDRESS: Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee. Registration District No. 7
City of Owyhee (No. ....., ... St.) Primary Registration District No. 1007
File No. 9146
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Delappe.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1842 (Year)

7. AGE: 72 yrs. 0 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Dont Know.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Brittana Edwards

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry A. Delappe
(Address) Oreana Ida.

15. Filed Oct 26 1914 Dy S D Calonge Local Registrar
Anna Hafner Deputy Reg

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from not at all 191.., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy-

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Koos M. D.
Oct 26 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn. DATE OF BURIAL: Oct 26 1914

20. UNDERTAKER: S B Shellabarger ADDRESS: Nampa.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. 2006

File No. 9147

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herman Otten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Third of Oct 1914 (Month) (Day) (Year)

7. AGE — Yrs. — Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Canyon Co

10. NAME OF FATHER Herman Otten

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Lena Nice

13. BIRTHPLACE OF MOTHER (State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Otten

(Address) Nampa Ida

15. Filed Oct 27 1914 Dr S D Calvert Local Registrar

Deputy Reg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on Oct 25 1914, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Monitron

Was found dead in

bed in morning

(Duration) ..... Yrs, ... mos. 2 3 ds.

Contributory (Secondary) Premature birth

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Murray M. D.

191... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 10/27 1914

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 -M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9

Primary Registration District No. 1006

File No. 9148

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa (No. 6 Ave South St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kitty Ellen Lang

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Aug (Month) 29 (Day) 1828 (Year)

7. AGE: 86 Yrs. 2 Mos. - ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Thos Van Meter

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. O. Gilmore
(Address) Nampa

15. Filed Oct 30 1914 S D Calonge MD Local Registrar
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1914, to Oct 29 1914, that I last saw her alive on Oct. 29 1914 and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Old age

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murray M. D.

Oct 30 1914 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 10/30 1914

20. UNDERTAKER: F K Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SUPS. 04659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006.
(No. ..... St.)

File No. 9149
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans Georg Holm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 25 (Day) 1867 (Year)

7. AGE: 46 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A C Jacobsen
(Address) Nampa Ida

15.
Filed Nov 10 1914 DVSD Canyon Co. Local Registrar
Anna Hatfield Deputy

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1914, to Nov 8 1914
that I last saw him alive on Nov 8 1914,
and that death occured on the date stated above, at 6:30 P. M.
The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) not known Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Murray M. D.
Nov 9 1914 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? not known
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Kohlerstown Cemetery — DATE OF BURIAL: Nov 10 1914

20. UNDERTAKER: F. K. Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9150

Registered No. 28

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

Registration District No. 126

Primary Registration District No. 2204

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George N Herrington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Nov (Month) 24 (Day) 1867 (Year)

7. AGE: 51 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Schoolteacher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: S. G. Herrington

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: [illegible] Beeler

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. E. Herrington

(Address) Cataldo Idaho

15. Filed Nov 7 1914 R B Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1914 to Oct 25 1914, that I last saw h[illegible] alive on Oct 25 1914 and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows: Typhoid fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Regen M. D.

Oct 27 1914 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison

DATE OF BURIAL: Oct 27 1914

20. UNDERTAKER: E W Wheeler

ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BOOK. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
File No. 95
Registered No. 69
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara J. M. Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fm.	W.	Single

6. DATE OF BIRTH
Aug (Month) 7 (Day) 18 1866 (Year)

7. AGE
48 yrs. 2 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Minn.

10. NAME OF FATHER P. J. Peterson.

11. BIRTHPLACE OF FATHER
(State or Country) Norway

12. MAIDEN NAME OF MOTHER Marthea Nelson.

13. BIRTHPLACE OF MOTHER
(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Dikka Peterson
(Address) Moscow Idaho

15.
Filed Nov 6 1914 D F Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to Oct 1914, that I last saw h alive on April 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma. (Tongue)

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wiik M. D.
Nov. 6 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	10/8 1914
20. UNDERTAKER Leo Stitz	ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 601
Primary Registration District No. 2141
File No. 9158
Registered No. 68

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Erickson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 15 1892 (Month) (Day) (Year)

7. AGE: 22 yrs. 1 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Latah Co

10. NAME OF FATHER: A. E. Erickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Amanda Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F Dalberg
(Address) Moscow

15. Filed Oct 26 1914 L B McCartin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 25 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to Did not see her alive 191, that I last saw h..... alive on ..... 191, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Homicidal. (Murdered)

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L B McCartin Coro. M. D.
Oct 26 1914 (Address) Mos Cor

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: Oct 27 1914

20. UNDERTAKER: K Cole acting
ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 9153
Registered No. 67

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caroline Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 18 (Day) 1838 (Year)

7. AGE: 76 yrs. 5 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: Sweden

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Jonson.

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Gustafson
(Address) Moscow Idaho

15. Filed Oct 29 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 29th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22nd 1913, to Oct 28 1914
that I last saw h[er] alive on Oct 25 1914
and that death occurred on the date stated above, at 12 60 M.

The CAUSE OF DEATH* was as follows:
Intestinal Stasis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Pelvic Growth
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas L. Patterson M. D.
19.... (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Nov 1 1914

20. UNDERTAKER: Geo Kelly — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 3141
(No. ..... St.)

File No. 9154
Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ester Lillian Downey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: April (Month) 23 (Day) 1914 (Year)

7. AGE: ..... yrs. 5 mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow

10. NAME OF FATHER: W. N. Downey

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Virginia Larson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Cooper
(Address) Moscow

15. Filed Oct 12 1914 J. P. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12 1914, to Oct 12 1914 that I last saw her alive on Oct 12 1914 and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Clarke M. D.
19 ..... (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: Oct 13 1914

20. UNDERTAKER: J. W. Cooper acting
ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 915
Registered No. 57

2. FULL NAME Irmgfred E Kramer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 19 (Day) 1914 (Year)

7. AGE: ..... yrs. 3 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow

10. NAME OF FATHER: Edward Kramer

11. BIRTHPLACE OF FATHER (State or Country): N Carolina

12. MAIDEN NAME OF MOTHER: Gertrud Duckett

13. BIRTHPLACE OF MOTHER (State or Country): N. Car

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. E Garren
(Address) Moscow

15. Filed Oct 27 191.. D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from never saw to Nov eleven 191.., that I last saw h..... alive on ..... 191.., and that death occurred on the date stated above, at from 1630 P M.

The CAUSE OF DEATH* was as follows:
Found dead in bed
Cause not known

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D F Rae M. D.
Oct 27 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: Oct 27 1914

20. UNDERTAKER: Geo Stitz
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 9156
Registered No. 60

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. Gritman Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julius Christenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH: Feb (Month) 13 (Day) 1863 (Year)

7. AGE: 51 yrs. 7 mos. 30 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Peter Christenson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Marion Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Christenson
(Address) Moscow Idaho

15. Filed Oct 16 1914 A. F. Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1914, to Oct. 13, 1914, that I last saw him alive on Oct. 13 1914, and that death occurred on the date stated above, at 7:10 P.M.

The CAUSE OF DEATH* was as follows:

Surgical Shock

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) An attempt at vaccination

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

10/15 1914 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Oct 16 1914

20. UNDERTAKER: Geo. Kelly — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 10 11
(No. Gritman Hospital St.)

File No. 9157
Registered No. 64
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah V Oyler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 21 (Day) 1857 (Year)

7. AGE: 56 yrs. 11 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Ills

10. NAME OF FATHER Paul F Welker

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Elizabeth Lyons

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M Oyler
(Address) Crescent. Idaho

15. Filed Oct 17 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1914, to Oct 16 1914, that I last saw her alive on Oct 16 1914 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchopneumonia
Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.
10/17 1914 (Address) E. Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Crescent Idaho — DATE OF BURIAL: Oct 17 1914

20. UNDERTAKER: Geo Stutz — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

Primary Registration District No. 10.

File No. 9158

Registered No. 62

County of .....

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl F Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1839 (Year)

7. AGE: 74 yrs. 11 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Retd Farmer

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E T Christenson
(Address) Moscow

15. Filed Oct 23 1914 J F Ross Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1914, to Oct. 14 1914, that I last saw him alive on Oct. 14 1914, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Paralysis, acute intoxication

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Mitral Insuf.

(Duration) ..... yrs. ..... mos. 63 ds.

(Signed) Chas. L. Gilman M. D.

10/23 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bear Creek | DATE OF BURIAL: Oct 24 1914

20. UNDERTAKER: Geo Kelly | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. ~~14~~ 61
Primary Registration District No. 1011
(No. Gritman Hospital St.)

File No. 9159
Registered No. 63
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Howell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F. M.	White	married

6. DATE OF BIRTH: Sept. 16 (Month) (Day) 1880 (Year)

7. AGE: 28 yrs. 1 mos. 6 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: D. C. Inman

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Ferguson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ed. Howell
(Address) Palouse

15. Filed Oct 23 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 21 1914, to October 23 1914, that I last saw h[er] alive on Oct 23 1914, and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:
Puerperal Septicemia

(Duration) yrs. mos. ds.
Contributory (Secondary) Child birth
(Duration) yrs. mos. ds.

(Signed) Chas. L. Gritman M. D.
10/23 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos.2.days. In the State..yrs..mos..days.
Where was disease contracted if not at place of death? Kamiah, Idaho
Former or usual residence Kamiah, Idaho

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: Oct 23 1914

20. UNDERTAKER: Geo Skelly
ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1911
(No. Gritman's Hospital St.)

File No. 6100
Registered No. 64
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Neff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F M	W	

6. DATE OF BIRTH: Oct (Month) 26 (Day) 1905 (Year)

7. AGE: 14 yrs. mos. ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Clarkston Wn

10. NAME OF FATHER John Neff

11. BIRTHPLACE OF FATHER (State or Country) Pen

12. MAIDEN NAME OF MOTHER Amy N Craig

13. BIRTHPLACE OF MOTHER (State or Country) Cal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Amy N. Neff.
(Address) Kamiah Ida.

15. Filed Oct 29 1914 D. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 25 1914, to Oct. 27 1914, that I last saw her alive on Oct 27 1914, and that death occurred on the date stated above, at 11:15 M.

The CAUSE OF DEATH* was as follows:
Suppurative Appendecitis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Punctured [illegible]
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Gritman M. D.
19..... (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Kamiah, Idaho
Former or usual residence Kamiah, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	9/29 1914
20. UNDERTAKER	ADDRESS
Geo Foltz	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 9167
Registered No. 65

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abraham Mathis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Married

6. DATE OF BIRTH 1832
March (Month) 7 (Day) 1832 (Year)

7. AGE
82 yrs. 7 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Sally Armour

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt-G. Wood
(Address) Moscow

15.
Filed Oct 24 1914 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1914, to Oct 15 1914, that I last saw h im alive on Oct 15 1914, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Ischaemia Angina Pectoris

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gutman M. D.
10/24 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 9/25 1914

20. UNDERTAKER — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 9162
Registered No. 11

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ed & Stella

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Feb (Month) 4 (Day) 1909 (Year)

7. AGE: 5 yrs. 8 mos. 1 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Genesee

10. NAME OF FATHER: Ed Stella

11. BIRTHPLACE OF FATHER (State or Country): Genesee

12. MAIDEN NAME OF MOTHER: F. Porter

13. BIRTHPLACE OF MOTHER (State or Country): Genesee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Stella
(Address) Moscow

15. Filed Oct. 6th 1914 W. H. Shem Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1914, to Oct 3 1914, that I last saw h— alive on Oct 3 1914, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Injury, Accident

(Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Setback following operation on injured leg
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Thorn M. D.
Oct 6, 1914 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Genesee
DATE OF BURIAL: 9/6 191

20. UNDERTAKER: Geo Stella
ADDRESS: Moscow

SYMS - YORK CO., PTGS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. Greencreek

Primary Registration District No.

File No. 9163

Registered No.

County of Idaho

City of Greencreek (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gaspar Hunzel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

Apr. (Month) 3 (Day) 1838 (Year)

7. AGE

76 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Peddler

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed June 6 1914 Rev. J. J. M. Baerlocher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I last saw h alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

old age & exposure

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 20 yrs. mos. days. In the State 20 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL June 6 1914

20. UNDERTAKER Nau — ADDRESS Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Carmen
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 9166
Registered No. 50
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hozen Russell Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 5 (Day) 1900 (Year)

7. AGE: 14 yrs. 1 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lemhi Co. Ida.

10. NAME OF FATHER: Joseph M Clark

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Edith Josephine Hocker

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E J Clark.
(Address) Carmen, Idaho.

15.
Filed October 16 — 1914 Helen L Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1914, to Oct 14 1914, that I last saw h-- alive on Oct 14 1914, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Hemorrhage, caused by biting jugular vein and trying - duration 7 days.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Hemophilia
(Duration) About 10 years yrs. ..... mos. ..... ds.
(Signed) Chas. F. Hunter M. D.
10/20 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery | DATE OF BURIAL: Oct 16th 1914

20. UNDERTAKER: John C Dobbs | ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 9167
Registered No. 51
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Auguste Hank

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 28" (Month) (Day) 1857 (Year)

7. AGE: 59 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Karl Haverman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Emilea Pagel

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Herman Hank
(Address): Salmon Idaho.

15. Filed NOV -2 1914 191 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October 31" (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1914 to Oct 17 1914, that I last saw h[illegible] alive on Oct 17 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
Probably one year
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Hammer M. D.
11-2 1914 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery | DATE OF BURIAL: Nov 2" 1914

20. UNDERTAKER: W. C. Doebler | ADDRESS: Salmon Idaho

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Winchester

Registration District No. 48
Primary Registration District No. 2127
(No. ....., ... St.)

File No. 9165
Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maud Sawyer Kuhl

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: August (Month) 28th (Day) 1886 (Year)

7. AGE: 28 yrs. 1 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: John Sawyer

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Simonson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maud Kuhl
(Address)

15. Filed 10 - 4 - 1914 Edward B. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 4th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1914, to Oct. 4th 1914, that I last saw her alive on Oct. 4th 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis general

(Duration) Probable 6 yrs. ..... mos. ..... ds.

Contributory (Secondary) Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. One ds.

(Signed) H. McLaughlin M. D.

Oct. 4th 1914 (Address) Winchester Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rhinelander Wisc
DATE OF BURIAL: — 191...

20. UNDERTAKER: H. R. Merchant
ADDRESS: Clarkston, Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

File No. 9169

County of Idaho

Primary Registration District No. 2184

Registered No. 11

City of Stites (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Gilbert Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH: Aug (Month) 16 (Day) 1854 (Year)

7. AGE: 60 yrs. 1 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coos County Oregon

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C O Pell
(Address) Stites Idaho

15.
Filed Oct 30 1914 J M Verbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1914, to Oct 3 1914, that I last saw him alive on Sept 23 1914, and that death occurred on the date stated above, at 2 10 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymalous Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Verbeck M. D.
Oct 3 1914 (Address) Lowell - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cemetery Stites | DATE OF BURIAL: Oct 4 1914

20. UNDERTAKER: None | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

County of Idaho

Primary Registration District No. 2184

File No. 91[illegible]

City of Kootenai (No. ....., ... St.)

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Crystal Viola Greer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 31 (Day) 1910 (Year)

7. AGE: 4 yrs. 7 mos. 13 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kootkia - Idaho

10. NAME OF FATHER: E. P. Greer

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Althi Canfield

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E P Greer
(Address) Kootkia - Idaho

15.
Filed Oct 6 1914 Jm. Verbeckmus
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept- (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1914, to Sept- 14 1914, that I last saw her alive on Sept- 14 1914 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Peritonitis resulting from Appendecitis

.....(Duration) .....yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J m Verbeckmus M. D.

Sept-14 1914 (Address) J m Verbeckmus Kootkia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kootkia Cemetery

DATE OF BURIAL: Sept- 15 1914

20. UNDERTAKER: None

ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

County of Idaho

Primary Registration District No. 2184

File No. 9171

City of Sites (No. ....., ... St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sister H. Prettyman

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Widowed

6. DATE OF BIRTH: Jan 30 (Month) (Day) 1841 (Year)

7. AGE: 73 yrs. 7 mos. 11 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Delaware

10. NAME OF FATHER: James Prettyman

11. BIRTHPLACE OF FATHER (State or Country): Delaware

12. MAIDEN NAME OF MOTHER: Sarah Jones

13. BIRTHPLACE OF MOTHER (State or Country): Delaware

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Rooney
(Address) Sites Idaho

15. Filed Oct 5 1914 J.M. Verhurkmas Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 19 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1914, to Sept 19 1914 that I last saw him alive on Sept 16 1914 and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Bronchs pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.M. Verhurkmas M. D.

Sept 20 1914 (Address) Yoakim Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
I. O. O. F. Cemetery Sites Idaho	Sept 20 1914

20. UNDERTAKER	ADDRESS
Rev. Eastman Parson	Sites Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 91[illegible]
Registered No. .....

Registration District No. 32
Primary Registration District No. 2049
(No. .... St.)

1. PLACE OF DEATH.
County of Kootenai
City of Santa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 19 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ~
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Moses Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Martin Hewitt
(Address) St Maries Idaho

15. Filed Oct. 30 1914 N. Mulcahy
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Eclampsia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) N. E. Cornwall M. D.
10/30 1914 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Oct 31 1914

20. UNDERTAKER: N. E. Mulcahy — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 9173
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Raffale Salisi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Unknown (Day) 1 (Year)

7. AGE: about 35 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Naked on Section
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) N. L. Mulcahy
(Address) .....

15. Filed Oct. 27 1914 N. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1914, to Oct 26 1914, that I last saw h... alive on Oct 26 1914 and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Brights Disease
Uremia

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. O'Connell M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Nov. 2 1914

20. UNDERTAKER: N. L. Mulcahy — ADDRESS: St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 9171
Registered No. .....

1. PLACE OF DEATH.
County of Nortonai
City of St Maries
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Rambo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH.
..... (Month) 1 (Day) ..... (Year)

7. AGE
38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Bridge Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Va

10. NAME OF FATHER
A. Rambo

11. BIRTHPLACE OF FATHER
(State or Country) Va

12. MAIDEN NAME OF MOTHER
Sally Scott

13. BIRTHPLACE OF MOTHER
(State or Country) Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. S. Rambo
(Address) Damascus, Va

15.
Filed Oct. 14 1914 H. L. Mulcahy
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1914, to Oct 14 1914, that I last saw him alive on Oct 14 1914, and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Electric burns

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

10/15 1914 (Signed) D. Bloomenvalle M. D.
(Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cabell Abingdon Va — DATE OF BURIAL — 191

20. UNDERTAKER H. L. Mulcahy — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 9175
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E. Harrigan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 3. (Day) 1894. (Year)

7. AGE: 20 Yrs. 7 Mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mills Center Miss

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Patrick Harrigan Ireland

12. MAIDEN NAME OF MOTHER: Catherine Hogan

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edith Harrigan
(Address) St Maries.

15. Filed Oct 28 1914 H L Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental Thrown from
Log jammer - Skull Fractured -
Left fractured -
(Duration) Yrs. Mos. ds.
Contributory (Secondary) Shock accompanied & followed accident.
(Duration) yrs. mos. ds.

(Signed) John Bruce Shepard M. D.
19 (Address) Coeur d'Alene Kootenai County.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Ida — DATE OF BURIAL: Nov 1 1914
20. UNDERTAKER: H L Mulcahy — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. .... St.)

File No. 9176
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Blomberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1869 (Year)
7. AGE: 46 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Worked in lumber
(b) General nature of industry, business, or establishment in which employed (or employer): camp.
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER: Andrew Johnson
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Annie Hanson
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Blomberg
(Address) Avery, Idaho
15. Filed Oct. 23 1914 N. Le Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1914, to Oct 22 1914, that I last saw him alive on Oct 22 1914 and that death occured on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) N. Le Mulcahy M. D.
1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Maries — DATE OF BURIAL: Oct. 25 1914
20. UNDERTAKER: N. Le Mulcahy — ADDRESS: St Maries

YMS - YORK CO., PTRS. & SONS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 91

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of St. Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Sipple

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 29 Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Bennett

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Linsbiger

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Sipple

(Address) St Maries, Idaho

15.

Filed Oct 20 1914 H L Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1914, to Oct 20 1914, that I last saw h[er] alive on Oct 20 1914 and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Post-Partum Hemorrhage

..... (Duration) ..... Yrs. ..... mos. 1½ hrs. ds.

Contributory (Secondary) .....

..... (Duration ..... Yrs. ..... mos. ..... ds.

(Signed) H L Cornwall M. D.

19..... (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Oct 21 1914

20. UNDERTAKER: H L Mulcahy — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)
File No. 91
Registered No. .....

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. N. Crawford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE about 68 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Ill. U.S.A.

10. NAME OF FATHER
" "

11. BIRTHPLACE OF FATHER
(State or Country) " "

12. MAIDEN NAME OF MOTHER
" "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. L. Mulcahy
(Address) Wallace

15.
Filed Oct. 19 1914 H. L. Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17 1914, to Oct. 18 1914, that I last saw h alive on Oct. 18 1914, and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Acute Pericarditis
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H Clubson M. D.
10/19 1914 (Address) Burke, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portland Or
DATE OF BURIAL: .....191.....

20. UNDERTAKER: H. L. Mulcahy
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9179

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Santa,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. J. Nilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Aug. (Month) 5 (Day) 1852 (Year)

7. AGE: 61 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Columbus Ohio

10. NAME OF FATHER: James Wilson

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Elizabeth Harbour

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ophelia Maguire

(Address) Moscow Idaho

15. Filed Oct. 12 1914 N. L. Mulcahy. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1914, to Oct 10 1914, that I last saw him alive on Oct 10 1914, and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, fibroid Cord.

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary): Debility & Cord.

(Duration 2 yrs. — mos. — ds.

(Signed) C. H. Kinsbury M. D.

Oct 12 1914 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Santa Ida.

19. PLACE OF BURIAL OR REMOVAL: Santa. DATE OF BURIAL: Oct 13 1914

20. UNDERTAKER: N L Mulcahy ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 9180
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry F Feley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Don't know~~ Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Jack
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ~~Missouri~~ ~~don't know~~

10. NAME OF FATHER: Alex Feley ~~don't know~~

11. BIRTHPLACE OF FATHER (State or Country): Ohio ~~don't know~~

12. MAIDEN NAME OF MOTHER: S. South ~~don't know~~

13. BIRTHPLACE OF MOTHER (State or Country): Ohio ~~don't know~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. N. Freely
(Address) Taylors Nash.

15. Filed Oct 9 1914 N. La Mukelvy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1914, to Oct 7 1914, that I last saw him alive on Oct 7 1914, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Gangrene following
compound fracture of leg due
to injury

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary): Old age

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen D Hall M. D.
Oct 7 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....daya. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries. DATE OF BURIAL: Oct 9 1914

20. UNDERTAKER: N. La Mukelvy ADDRESS: St Maries.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Mad.

City of Burton

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 9183

Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rhoda Ann Beattie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 17 (Day) 1857 (Year)

7. AGE: 55 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. P. Watson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Glenn

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Beattie

(Address) Burton

15. Filed 10-28 1914

G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-28 1914, to 10-28 1914, that I last saw h[illegible] alive on 10-28 1914, and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows: Acute cardiac dilatation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. G. Espe M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton

DATE OF BURIAL: 10/31 1914

20. UNDERTAKER: John Phillips

ADDRESS: Replume

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 109
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 9184
Registered No. 63

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lottie J. Berry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 17 (Day) 1880 (Year)

7. AGE: 34 Yrs. 5 Mos. 10 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William H. Hoskins

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Charlotte Jenkins

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carrie Hoskins
(Address) Wilford, Utah

15. Filed 10-22 1918
G. L. Esplin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 22 (Day) 191 8 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-15 191 8 to 10-22 191 8, that I last saw h[illegible] alive on 10-2 191 8, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Shupe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford — DATE OF BURIAL: 10/25 1918

20. UNDERTAKER: J. Rigby — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 9185
Registered No. 62

1. PLACE OF DEATH.
County of Jefferson
City of Rexburg
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alvin LeRoy Bybee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 30 (Day) 1914 (Year)

7. AGE: ....Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo. LeRoy Bybee

11. BIRTHPLACE OF FATHER (State or Country): ~~Idaho~~ Montpelier

12. MAIDEN NAME OF MOTHER: Evalene Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Bybee
(Address) Rexburg

15. Filed 10-22 1914
G. L. Espe
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to Oct 22 1914, that I last saw h~~im~~ alive on Oct 21 1914, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Starvation
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary)
.....(Duration) .....yrs. .....mos. .....ds.

(Signed) G. L. Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: Oct 24 1914

20. UNDERTAKER: F. M. Williams — ADDRESS: Rex.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 9186
Registered No. 61

1. PLACE OF DEATH.
County of Madison
City of Lyman

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Soren P. Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Jan (Month) 28 (Day) 1864 (Year)

7. AGE 50 Yrs. 8 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Soren P Peterson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Elisabeth Sorenson

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Peterson Per Ray-
(Address) Lyman

15.
Filed 10-19 1914 G G Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-15 1914, to 10-19 1914, that I last saw h~~im~~ alive on 10-18 1914 and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) G G Estes M. D.
1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Archer	10/21 1914
20. UNDERTAKER Heyrung	ADDRESS Ryburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 9167
Registered No. 62

1. PLACE OF DEATH.
County of Madison
City of Sunnydale
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Halley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Mr Halfred

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Adelaide Mrs Mudry

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Hillyman
(Address) Sunnydale

15. Filed 10-19 1914 G L Estep Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1914, to Oct 18 1914, that I last saw h[illegible] alive on Oct 18 1914, and that death occured on the date stated above, at 9:50 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia, Lobar

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary): None
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jos. J. Walker M. D.
19 .... (Address) Ryeburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ryeburg — DATE OF BURIAL: 10-20 1914

20. UNDERTAKER: John Phillips — ADDRESS: Ryeburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKBS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2176
File No. 9188
Registered No. 54

1. PLACE OF DEATH.
County of Fremont.
City of Egin
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parley Clayton Martensen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. September 13 1913 (Month) (Day) (Year)

7. AGE: 1 Yrs. 1 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dubois Idaho.

10. NAME OF FATHER: Parley P Martensen

11. BIRTHPLACE OF FATHER (State or Country): Grover Utah

12. MAIDEN NAME OF MOTHER: Maud V. Rummel

13. BIRTHPLACE OF MOTHER (State or Country): Latank Colorado.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Rodeheaver
(Address) Ashton Idaho

15. Filed 11-10 1914 Gly Cooke Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 17 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1914, to Oct 17 1914, that I last saw him alive on Oct 16 1914, and that death occured on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Phthisis Infantum.
Marasmus.

4 Weeks (Duration) — Yrs. — mos. — ds.
Contributory (Secondary) Phthisis Infantum
— (Duration) — yrs. — mos. — ds.
(Signed) J. W. Rodeheaver M. D.
19 (Address) Egin Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Egin, Ida — DATE OF BURIAL: 10-19 1914

20. UNDERTAKER: F. M. Nielsons — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 100
Primary Registration District No. 2178

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9189
Registered No. 58

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna G. Dieterle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 14 (Day) 1898 (Year)

7. AGE: 16 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John F. Dieterle

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Gelder

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John F. Dieterle
(Address) Rexburg

15. Filed 10-15 1914 G. L. Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-30 1914, to 10-14 1914, that I last saw h— alive on 10-14 1914, and that death occured on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows: General peritonitis following rupture of bowel

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) G. L. Estes M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 10/16 1914

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTR. & STNR. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 160
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 9190
Registered No. 57

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel F. Cherry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 31 (Day) 1912 (Year)

7. AGE: 2 Yrs. 2 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salem

10. NAME OF FATHER: James Cherry

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nancy Dillee

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Cherry
(Address) Salem

15.
Filed 10-14 191X
G G Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1914, to Oct 11 1914, that I last saw h[illegible] alive on Oct 11 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis.

(Duration) Yrs. 7 mos. ds.
Contributory (Secondary) Pneumonia
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
19.... (Address) Sugar City Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ryburg — DATE OF BURIAL: 10/13 1914

20. UNDERTAKER: J Keyser — ADDRESS: Ryburg

BYRNE - YORK CO., PTRS. & BKBS. 24655

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 163

Primary Registration District No. 2481

File No. 9191

County of Idaho

City of Elk (No. ....., ... St.)

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma Ellen Hyde

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: August (Month) 6 (Day) 1886 (Year)

7. AGE: 28 yrs. 1 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Wife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Montana

10. NAME OF FATHER J C Litchfield

11. BIRTHPLACE OF FATHER (State or Country) Peterborough England

12. MAIDEN NAME OF MOTHER Sarah Elizabeth Smith

13. BIRTHPLACE OF MOTHER (State or Country) Cal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Litchfield
(Address) Elk City

15. Filed Nov 10 1914 G B Stutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated the death of deceased ~~191 , to 191 ,~~ that ~~I last saw him alive~~ on Oct 7th 1914, and that death occurred on the date stated above, at 1100 M.

The CAUSE OF DEATH* was as follows:
Homicide by firearms

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry B Blake M. D.
Oct 19 14 (Address) Coroner of Idaho County Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Elk City Idaho	Oct 6th 1914

20. UNDERTAKER	ADDRESS
W E Graham	Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9192

Registered No. 42

1. PLACE OF DEATH.
County of Idaho
City of Elk City
(No. ....., ... St.)

Registration District No. 103
Primary Registration District No. 2181

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hugh Kennedy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1893 (Year)

7. AGE: 21 yrs. ~~Xxx~~ mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stage Driver
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: A D Kennedy

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Ida Mary Dunham

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Allen Kennedy
(Address) Harpster Idaho

15. Filed Nov 10 1914 G S Sheldon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated ~~Oct~~, to the death of deceased ~~that I last saw h alive on~~ ..... 191..
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Homicide by firearms

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry B Blake M. D.
Oct 7 1914 (Address) Kentucky Idaho Co Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Oct 10 1914

20. UNDERTAKER: W E Graham
ADDRESS: Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 2181

File No. 919

County of Idaho

City of Harpster (No. ....., ... St.)

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Bullion

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: don't Know (Month) 15th (Day) ? (Year)

7. AGE: 65 yrs. - mos. - ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: don't Know

11. BIRTHPLACE OF FATHER (State or Country): don't Know

12. MAIDEN NAME OF MOTHER: don't Know

13. BIRTHPLACE OF MOTHER (State or Country): don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Sunridge

(Address) Harpster Idaho

15. Filed Nov 10 1914 G S Shutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) Sixteen (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1912, to October 10-1914, that I last saw him alive on October 10-1914 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Several yrs mos. ds.

Contributory (Secondary) Mitral Stenosis

(Duration) 2 yrs. - mos. - ds.

(Signed) W. H. Warner M. D.

10-16-1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Harpster | DATE OF BURIAL: Oct 17 1914

20. UNDERTAKER: None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 9194
Registered No. 40
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Robert Kiper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH
September 30th 1859
(Month) (Day) (Year)

7. AGE
55 yrs. ..... mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Labourer and
(b) General nature of industry business, or dstablishment in which employed (or employer) clerk in store

9. BIRTHPLACE (State or Country) Kentucky white Mills

10. NAME OF FATHER James Kiper

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Catharine Allen

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarak Swan X
(Address) Grangeville

15.
Filed Nov 10 1914 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct 7 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1914 to Oct 7 1914
that I last saw him alive on Oct 6 1914
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Asthma

(Duration) unknown yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) unknown yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
Oct 7 1914 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: Oct 10th 1914

20. UNDERTAKER: E J Hancock | ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.
County of Idaho
City of Grangeville
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 103
Primary Registration District No. 2781
(No. ....., ... St.)

File No. 9195
Registered No. 38
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Benoy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: May (Month) 24 (Day) 1838 (Year)

7. AGE: 76 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E L Henlee
(Address) Grangeville Idaho

15. Filed Nov 10 1914 G S Stricklin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1914 to Oct 13 1914, that I last saw him alive on Oct 9 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Arteris-Sclerosis
(Duration) unknown yrs. ..... mos. ..... ds.

(Signed) G S Stricklin M. D.
Oct 14 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fair View — DATE OF BURIAL: Oct 14 1914

20. UNDERTAKER: W E Graham — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

File No. 9196

County of Idaho

City of Grangeville (No. ....., ... St.)

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Bourgard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH

Sept (Month) 27 (Day) 1837 (Year)

7. AGE

77 yrs. ~ mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. N. Walker

(Address) Grangeville Idaho

15.

Filed Nov 10 1914 G. S. Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October (Month) 16th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated the death of said deceased ~~191~~ to ~~191~~, ~~that I last saw h~~ alive on Oct 14th 1914 and that death occurred on the date stated above, at about 12 A.M.

The CAUSE OF DEATH* was as follows:

Causes (Natural) Unknown

~~(Duration)~~ ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile debility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry B. Blake M. D.

Oct 17 1914 (Address) Coroner Idaho County Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Oct 19 1914

20. UNDERTAKER: W E Graham — ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

File No. 9197

County of Idaho

City of Grangeville (No. ....., ... St.)

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas K. Holmes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: August 25th (Month) (Day) 1834 (Year)

7. AGE: 77 yrs. 2 mos. 9 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Crapenter
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Albina Holmes
(Address) Grangeville, Idaho.

15.
Filed Nov 10 1914 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1914 to Nov 3 1914 that I last saw him alive on Nov 2 1914 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) Don't Know yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

Nov 4 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho | DATE OF BURIAL: Nov 5 1914

20. UNDERTAKER: W E Graham | ADDRESS: Grangeville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77 1

County of Madison

Primary Registration District No. 2176

City of Felt

(No. ....., ... St.)

File No. .....

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton L Hendrickson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH

April (Month) 2 (Day) 1870 (Year)

7. AGE

44 yrs. 5 mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER James Hendrickson

11. BIRTHPLACE OF FATHER (State or Country) ~~Iowa~~ Ohio

12. MAIDEN NAME OF MOTHER Martha J Langley

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. L. Hendrickson

(Address) Felt Idaho

15.

Filed 9 15 1914 C. C. Shevering Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sep (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. Nagel M. D.

19.... (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Felt Idaho | DATE OF BURIAL: 9.15.1914

20. UNDERTAKER: Hoke & Gough | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

County of Madison

Primary Registration District No. 2176

File No. ( )

City of Rell (No. , St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Hendrickson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: November 9 1860 (Month) (Day) (Year)

7. AGE: 53 yrs. 10 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: James Hendrickson

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Martha Jane Langley

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alfred Hendrickson
(Address) Rell Ida.

15. Filed 9-9 1914 C. E. Sherman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September 8 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 191 , that I last saw h alive on ..... 191 , and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

1. Cerebral Hemorrhage
2. No Physician

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rell Idaho

DATE OF BURIAL: 9-10 1914

20. UNDERTAKER: Dan L. Green

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

D. C. DRIGGS,
PSESIDENT
V. C. HEGSTED,
VICE-PRESIDENT

Teton Valley Supply Co.

J. M. SEWELL,
GEN'L. MGR. & SEC'Y.
C. CHERRINGTON,
ASST. SEC'Y. & TREAS.

INCORPORATED

CAPITAL :: $50,000

Driggs, Idaho,

Wednesday,

September 9th, 1914.

We, the undersigned having examined the body of Alfred Hendricksen, declare him dead, same showing no signs of an unatural death, and that he died within a few hours after he (Deceased) felt pains in the backmof his neck, no physician attending the case.

.....

.....

.....

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

County of Madison

Primary Registration District No. 2176

City of Lawson (No. ....., ... St.)

File No. 9

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reinhold Charles Hansen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 18 (Day) 1905 (Year)

7. AGE: 8 yrs. 7 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ezra Charles Hansen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lettie Mack

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. C. Hansen
(Address) Lawson Idaho

15. Filed 7 3 191 4 Clemens Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1914 to July 3 1914
that I last saw him alive on June 29 1914,
and that death occurred on the date stated above, at 7:45 P.M.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) Acute Articular rheumatism

(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) Dr. Ora D. Keith M. D.

7/21 1914 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lawson — DATE OF BURIAL: July 6 1914

20. UNDERTAKER: Alfred Hansen — ADDRESS: Lawson

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No.
Registered No. 22

1. PLACE OF DEATH.
County of Madison
City of Lawson (No.) St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pearl Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: July (Month) 26 (Day) 1914 (Year)

7. AGE: ....yrs. ....mos. ....ds.
IF LESS than 1 day how many ...2.. hrs. or ..30.. mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lawson

10. NAME OF FATHER David Hansen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Adeline Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Hansen
(Address) Lawson, Idaho

15. Filed July 191[illegible] [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191..., to ....191...,
that I last saw h....alive on ....191...,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Premature birth

.....(Duration)....yrs....mos. 1/6 ds.
Contributory
(Secondary)
.....(Duration)....yrs....mos....ds.
(Signed) Ora Smith M. D.
7/27 1914 (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lawson | DATE OF BURIAL: July 28 191[illegible]

20. UNDERTAKER: Alfred Hansen | ADDRESS: Lawson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9202
Registered No. 15

1. PLACE OF DEATH.
County of Madison
City of Driggs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77
Primary Registration District No. 7176
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Preston Davidson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single
6. DATE OF BIRTH: Feby (Month) 13 (Day) 1912 (Year)
7. AGE: 1 yrs. 11 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: William T Davidson
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Florence Bowler
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William P. Davidson
(Address) Driggs 1915
15.
Filed 2-2- 191 4 L. L. Harrington Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 2nd (Day) 191 4 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1914 to Feb 2 1914,
that I last saw him alive on Feb 2 1914,
and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH was as follows: Pneumonia Fever
(Duration) yrs. mos. 17 ds.
Contributory (Secondary):
(Duration) yrs. mos. ds.
(Signed) Ora D Keith M. D.
2/11 1914 (Address) Driggs Ida

State the DISEASE CAUSING DEATH, as in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Driggs
DATE OF BURIAL: 2-4- 191 4
20. UNDERTAKER: L. L. Harrington
ADDRESS: Driggs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 9207
Registered No. 16

1. PLACE OF DEATH.
County of Madison
City of Paris
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hyrum Thomas Paris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
2 (Month) — 8 (Day) — 1914 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ernest Geo Paris

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mary Ellen Brown

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Geo Paris
(Address) Paris Idaho

15.
Filed 2-10 1914 Mc Pherrington
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
2 (Month) — 9 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 8th 1914, to Febry 9th 1914, that I last saw him alive on Febry 9th 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Concussion

(Duration) ..... yrs. ..... mos. 1 ds.
Contributory 12½ hours
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Emmett J. Beesley M.D.
2/9 1914 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Paris — DATE OF BURIAL 2-11 1914

20. UNDERTAKER Thos A Hansen — ADDRESS Paris

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 77
County of Madison Primary Registration District No. 2176
City of Driggs (No. ....., ... St.)
File No. ( )
Registered No. 17
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: 2 (Month) 22 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Driggs Idaho

10. NAME OF FATHER: William R. Pascoe

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Cassie Gessler

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm R Pascoe
(Address): Driggs

15. Filed 3-1-1914 C Sherrard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1914, to March 1 1914 that I last saw her alive on Feb 25 1914, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Bronchitis

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ora D Keist M. D.
3/2 1914 (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Driggs Idaho — DATE OF BURIAL: 3-2-1914

20. UNDERTAKER: C A Larsen — ADDRESS: Driggs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

Primary Registration District No. 2176

File No. 9[illegible]

Registered No. 18

County of Madison

City of Rawson (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie E. Richo

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 20 (Day) 1912 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..1.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Rawson Idaho

10. NAME OF FATHER: Frank E. Richo

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Vivian Peacock

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Richo

(Address) Rawson Idaho

15.

Filed Apr 21 1914 [illegible] Registrar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1914, to Apr 20 1914, that I last saw her alive on Apr 20 1914, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth,

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. 12 hrs

(Signed) Lena Triplett M. D.

Apr 22 1914 (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rawson — DATE OF BURIAL: Apr 20 1914

20. UNDERTAKER: L. D. Fullmer — ADDRESS: Rawson

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

County of Madison

Primary Registration District No. 2176

City of Irigo

File No. 920

(No. ..... St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elvira R. Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: February (Month) 26 (Day) 1912 (Year)

7. AGE: 2 yrs. 2 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Preston Idaho

10. NAME OF FATHER: Ray L. Davis

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Utah

12. MAIDEN NAME OF MOTHER: Ester Rodebeck

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray L Davis
(Address) Irigo, Idaho

15. Filed 5-2-1914 C. Cherrington Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30 1914, to May 1 1914, that I last saw h[illegible] alive on May 1 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Young M. D.

5/2 1914 (Address) Driggs, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Irigo — DATE OF BURIAL: 5-3-1914

20. UNDERTAKER: C. Cherrington — ADDRESS: Irigo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

Primary Registration District No. 2176

File No. [illegible]

County of Madison

City of Victor (No. ....., ... St.)

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Hatch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 6 (Day) 1914 (Year)

7. AGE: ....Yrs....Mos. 14 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Madison Co

10. NAME OF FATHER: Hyrum Hiles Hatch

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Maria Shaw

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H H Hatch

(Address) Victor Idaho

15. Filed 5-20 1914 E Merrill Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 4:30 PM 1914, to May 19 5:30 PM 1914, that I last saw her alive on May 19 1914, and that death occured on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) Broncho pneumonia

(Duration ....yrs. ....mos. 4 ds.

(Signed) Robt. W. King M. D.

19.... (Address) Victor, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 14 days In the State.....yrs.....mos. 14 days

Where was disease contracted if not at place of death? Place of death

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor

DATE OF BURIAL: 5-21-1914

20. UNDERTAKER: J L Lauritzen

ADDRESS: Victor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. — Registration District No. 24
County of Kootenai — Primary Registration District No. 1050
City of Coeur D'Alene (No. ....., ... St.)
File No. 2921
Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessee Baldwin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1883 (Year)

7. AGE: 30 yrs. 9 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: W. L. Baldwin

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Reddie Martin

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burton Gross
(Address)

15. Filed Oct 9 1914 Max C. Holand Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1914, to Sept 28 1914 that I last saw her alive on Sept 28 1914 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis, Tuberculous Laryngitis, Tuberculous Mastoiditis, (bilateral)

(Duration) Several yrs. mos. ds.

Contributory (Secondary) Myocardial degeneration

(Duration) yrs. several mos. ds.

(Signed) F Eppler M. D.
Oct 6 1914 (Address) Spokane Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Coin Iowa
DATE OF ~~BURIAL~~ removal: Oct 10 1914

20. UNDERTAKER: Gus Nelson
ADDRESS: Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 24

Primary Registration District No. 7050

File No. 92133

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

Registered No. 449

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Marguerite Glasford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1876 (Year)

7. AGE 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Alex Shanstrom

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Marguerite Shanstrom

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. J. Hawthorne

(Address) C D A

15. Filed Oct 28 1914 M C Standard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1908. 191..., to ..... 191...,
that I last saw h Ex alive on 1908 191...,
and that death occured on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:

Haemoptysis.

..... (Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) John J. Wood M. D.

Oct. 26 1914 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Lawn	Oct 28 1914
20. UNDERTAKER	**ADDRESS**
S J Lucas	C D A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1056
File No. 3 9215
Registered No. 1

1. PLACE OF DEATH.
County of Kootenai
City of C W A (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1873 (Year)

7. AGE
41 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Norway

10. NAME OF FATHER Hans Christopher

11. BIRTHPLACE OF FATHER
(State or Country) Norway

12. MAIDEN NAME OF MOTHER -

13. BIRTHPLACE OF MOTHER
(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin Johnson
(Address) C D A

15.
Filed Oct 25 1914 Max a. Dorland
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 16 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 12 1914, to Mch 12 1914, that I saw h er alive on Mch 12 1914, and that death occurred on the date stated above, at 10-00 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis (Pulmonary)

(Duration) Don't Know yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) W H Haldeman M. D.
4/17 1914 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Lawn	Apr 19 1914

20. UNDERTAKER	ADDRESS
S J Penn	C D A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 02168
Registered No. 2

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of J. E. Donald.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Oct. (Month) 24 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. E. Donald

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Blanche Modlin

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) J. E. Donald

15. Filed Oct 26 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24th 1914, to Oct 26th 1914
that I last saw her alive on Oct 26 1914
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Inanition

..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jno Bunby M. D.
Oct 26 1914 (Address) Jno

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem.
DATE OF BURIAL: Oct 26 1914

20. UNDERTAKER: Cassedy & Nelson
ADDRESS: Coeur D'Al

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 92
Registered No. 3

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Harry Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 21 (Day) 1902 (Year)

7. AGE: 12 yrs. 3 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coeur D'Alene

10. NAME OF FATHER: J. P. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Sallie Benson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John P Johnson
(Address) .....

15. Filed Oct 17 1914 Mark Sheets Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6" 1914, to Oct 14 1914
that I last saw h in alive on Oct 14 1914
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows: Perforation of bowel from Typhoid fever

(Duration) — yrs. — mos. 10 ds.
Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.
(Signed) W. H. Holden M. D.
Oct 14 1914 (Address) Coeur D'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Oct 18 1914

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 923
Registered No. 4

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick O'Neil

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 51 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John O'Neil

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Brigt Calhaun

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John O'Neil
(Address) .....

15. Filed Oct 31 1914 Max A. Norland Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 13 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1914, to Oct 13 1914, that I last saw him alive on Oct 13 1914, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Ruptured Gall Bladder

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Busby M. D.

Oct 13 1914 (Address) Coeur d'alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: Oct 15 1914

20. UNDERTAKER: S J Luer — ADDRESS: Coeur d Alene

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3 92
Registered No. 5

1. PLACE OF DEATH.
County of Gamard
City of Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29.
Primary Registration District No. 1050
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Ward.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (*Write* the word.)
M.	W.	

6. DATE OF BIRTH 12 (Month) Oct (Day) 1914 (Year)

7. AGE ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many 23 *hrs. or* ..... *mins.?*

8. OCCUPATION —
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Gamard Idaho.

10. NAME OF FATHER M. J. Ward.

11. BIRTHPLACE OF FATHER (State or Country) Canada.

12. MAIDEN NAME OF MOTHER Emma C Henry.

13. BIRTHPLACE OF MOTHER (State or Country) Can Paul Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. J. Ward.
(Address) .....

15. Filed Oct 15 1914 Mac Soland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1914, to ..... 191..
that I last saw h..... alive on Oct 12 1914,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Strangulation
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Myers M. D.
19.... (Address) Eden.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem. DATE OF BURIAL: Oct 13 1914.

20. UNDERTAKER: None. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of C. D'A.

Registration District No. 29
Primary Registration District No. 1050
(No. ..... St.)

File No. 3220
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Overton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 29 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coeur D'Alene

10. NAME OF FATHER: C. A. Overton

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Alcia Hasty

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Overton
(Address) Coeur d'alene Idaho

15. Filed Oct 31 1914 M. L. Gordon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 29 1914, to Oct 30 1914
that I last saw h-im alive on Oct 30 1914
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Encephalomeningocele.

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Hunter Kirkham M. D.
Oct 31 1914 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Oct 31 1914

20. UNDERTAKER: Cassidy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

29

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3 9221

Registered No. 7

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No.

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Luther Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 29 (Day) 1850 (Year)

7. AGE: 64 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Belville Ont.

10. NAME OF FATHER: Joseph Phillips

11. BIRTHPLACE OF FATHER (State or Country): York Stoke

12. MAIDEN NAME OF MOTHER: Lydia C. Clark

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Franklin B. Phillips
(Address) Coeur d'Alene

15. Filed Oct 20 1914 W. C. Haland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 25th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23d 1914, to Oct. 25th 1914, that I last saw him alive on Oct. 25th 1914, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Suppression of Urine

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Shock from Gunshot

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) John Busby M. D.

Oct. 30 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
McBain Mich.	Oct 31 1914

20. UNDERTAKER	ADDRESS
F. E. Kidd	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 704
City of Wallace (No. 5th, Street St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 922
Registered No. 66
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Perry G. Langdon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: February (Month) 7 (Day) 1857 (Year)

7. AGE: 57 yrs. 7 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: no trade
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): Not "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Horace Langdon
(Address) Wallace Idaho

15. Filed Oct 12 1914 F. Leo Quinby Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1914 to Oct 1 1914 that I last saw h-m alive on Sept 30 1914, and that death occurred on the date stated above, at 1300 M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Mowery M. D.
Oct 1 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Colfax Wash — DATE OF BURIAL: Oct. 3 1914

20. UNDERTAKER: W. W. Wastell — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

Primary Registration District No. 1014

File No. 92

Registered No. 67

County of Shoshone

City of Wallace (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Delonay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 22 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Frank Delonay

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Rosine Vallele

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Delonay

(Address) Pinnington Idaho

15. Filed Oct 4 1914 F. Les Irwin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1914, to Oct 2 1914, that I last saw him alive on Oct 2 1914, and that death occured on the date stated above, at 11 PM.

The CAUSE OF DEATH*, was as follows:

Traumatic Rupture of Bladder & Intestine also Multiple fracture of Left Femur

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary): None

(Duration) Yrs. mos. ds.

(Signed) D. H. Mowry M. D.

(Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Oct 5 1914

20. UNDERTAKER: [redacted] Lake Co — ADDRESS: Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SORS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1014
(No. Providence Hosp. St.)

File No. 97
Registered No. 68
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Leslie Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: ..... 1 (Month) (Day) (Year)
7. AGE: 23 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: Mortimer Wilson
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Mary Nichols
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Fargey
(Address) Wardner Idaho
15.
Filed Oct 5 1914 F. Leo Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1914, to Oct 5 1914, that I last saw him alive on Oct 4 1914, and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows: Fracture of base of skull thru fracture of Cervical Vertebrae
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary): None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D R Howard M. D.
Oct 5 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho. DATE OF BURIAL: Oct 5th 1914
20. UNDERTAKER: W. G. Worstell ADDRESS: Wallace Id

TYMS-YORK CO., PRINTERS & RINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. 405, Bank St. St.)

File No. 92
Registered No. 69
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thos. Buford Farris

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 30th (Day) 1914 (Year)

7. AGE: 0 yrs. 1 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Idaho

10. NAME OF FATHER: John C Farris

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary L. St. Germain

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John C Farris
(Address) Wallace Idaho

15. Filed Oct 9 1914 F. Leo Linsley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 8th (Month) Thursday (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from from birth 191..., to Oct 8th 1914, that I last saw h.. alive on Oct 7th 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Congenital Heart affection

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. S. Shaw M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho. DATE OF BURIAL: Oct. 10th 1914.

20. UNDERTAKER: Bruce G. Wardell ADDRESS: Wallace, Ida

YMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9296

Registered No. 70

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. ....., ... St.)

Registration District No. 70

Primary Registration District No. 1911

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Celesta .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 10 (Day) 1914 (Year)

7. AGE: Premature ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wallace Idaho

10. NAME OF FATHER: Frank Bills

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Dora McCoy

13. BIRTHPLACE OF MOTHER (State or Country): St Louis, Missouri

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Glass

(Address) Burke Ida

15. Filed 10/17 1914 F. Leo Zingle Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

..... (Month) ..... (Day) 191..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

..... (Duration) [redacted] Yrs. ..... mos. ..... ds.

Contributory (Secondary) [redacted] Mowery

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr Mowery M. D.

Oct 10 1914 (Address) City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Oct 12 1914

20. UNDERTAKER: Wards Undertaking Co. — ADDRESS: Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011 File No. 92
City of Wallace (No. Jersies Court, Deceased St.) Registered No. 71
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katheen Elanore O'Leary

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH: May (Month) 7 (Day) 1914 (Year)

7. AGE: 0 yrs. 5 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace, Idaho,

10. NAME OF FATHER: James Edward O'Leary

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Neita Sunderlin

13. BIRTHPLACE OF MOTHER (State or Country): Spokane Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Edward O'Leary
(Address) Wallace Idaho

15. Filed Oct 17 1914 F. L. Sunday Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1914, to Oct 12 1914, that I last saw her alive on Oct 12 1914, and that death occurred on the date stated above, at 6 00 M.

The CAUSE OF DEATH* was as follows:
Cerebrospinal Meningitis
(Duration) ..... yrs. ..... mos. 12 ds.
Contributory (Secondary): None
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Mowry M. D.
10/13 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Oct. 14 1914

20. UNDERTAKER: B. G. Worstell — ADDRESS: Wallace Ida

-YMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70

Primary Registration District No. 1914

File No. 922

Registered No. 77

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Cavanaugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... 1 ..... (Month) (Day) (Year)

7. AGE: 63 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Sutherland
(Address) Wallace Ida

15. Filed Oct 13 1914 F. Leo Sunday Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1914 to Oct 5 1914
that I last saw him alive on Oct 4 1914
and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:
Myocarditis Chronic
Degeneration & Broken Compensation
(Duration) yrs. 3 mos. ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) yrs. mos. ds.
(Signed) Dr. Moriarty M. D.
10/13 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Oct 14 1914

20. UNDERTAKER: C. C. Wooster
ADDRESS: Wallace

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9295

Registered No. 73

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital St.)

2. FULL NAME L L Parboy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: 84 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E B Thornhill
(Address) Kellogg Ida

15. Filed Oct 16 1914 F. Leo Tinsley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 11 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1914, to Oct 11 1914, that I last saw him alive on Oct 10 1914, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Suppurative Cystitis
(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Hyperkeratosis Crotalis
(Duration) 10 yrs. mos. ds.

(Signed) H H Mowery M. D.
1913 1914 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: Oct 17th 1914

20. UNDERTAKER: C C Wortman
ADDRESS: Wallace

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9231

Registered No. 75

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 104
(No. Providence Hosp. St.)

2. FULL NAME Martin Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1861 (Year)

7. AGE: 53 yrs. 10 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ribe Denmark Europe

10. NAME OF FATHER: Anders Christensen Andersen

11. BIRTHPLACE OF FATHER (State or Country): Ribe Denmark

12. MAIDEN NAME OF MOTHER: Ane Tonesen

13. BIRTHPLACE OF MOTHER (State or Country): Seistrup Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anderson
(Address) 311 - 4th Ave Spokane Wash

15. Filed Oct 24 1914
Local Registrar: A. Leo Lundy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22, 1914, to Oct 22 1914, that I last saw him alive on Oct 22 1914, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) yrs. mos. 10 ds.
Contributory (Secondary) Alcoholism
(Duration) yrs. 6 mos. ds.

(Signed) Dr. Mowry M. D.
Oct 23 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash
DATE OF BURIAL: Oct 24 1914

20. UNDERTAKER: Bruce & Worstell
ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 9232
Registered No. 7

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Williams Presley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1914 (Year)

7. AGE: 24 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hardiner

10. NAME OF FATHER: John Presley

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Winnifred McCauley

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Presley
(Address) Wallace Ida

15. Filed 10/25 1914 F. L. Turner Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1914, to Oct 24 1914
that I last saw him alive on Oct 24 1914
and that death occured on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) Dr Mowery M. D.
Oct 24 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: Oct 26 1914

20. UNDERTAKER: Ford Undertaking Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 92[illegible]
Registered No. 47

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Wale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 83 Yrs. —— Mos. —— ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: John Murphy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Hannah Driscoll

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wallace Idaho
(Address) Estate of Murphy

15. Filed Oct 29 1914 F. Leo Dunphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910, to Oct 1914, that I last saw her alive on Sept 1914, and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Previous attacks apoplexy
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Moriarty, M.D.
19 14 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Missoula Mont. DATE OF BURIAL: Oct 30 1914

20. UNDERTAKER: Nash Undertaking Co ADDRESS: Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 92[illegible]

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Rupert

2. FULL NAME Walter A Bull

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1875 (Year)

7. AGE 38 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Rancher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Henry Bull

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Anna M Nichols

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W A Bull

(Address) .....

15. Filed Nov 11 1914

O H Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1914, to Oct 4 1914, that I last saw h[illegible] alive on Oct 4 1914, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF ~~DEATH~~* was as follows: Shooting. By Revolver

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

11-11 1914 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery — DATE OF BURIAL Oct 6 1914

20. UNDERTAKER H. A Goodman — ADDRESS Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S, No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Minidoka
City of Rupert

Registration District No.
Primary Registration District No.
(No. ..... St.)
File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis G Mooney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 8 (Day) 1845 (Year)

7. AGE: 69 Yrs. ..... Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER: Brant Jolly

11. BIRTHPLACE OF FATHER (State or Country) dont Know

12. MAIDEN NAME OF MOTHER: Francis Jolly

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs F Mooney
(Address) .....

15. Filed 11/11 1914 — O S Lee, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to Oct 18 1914, that I last saw her alive on Oct 5 1914, and that death occured on the date stated above, at 5 00 M.

The CAUSE OF DEATH* was as follows:
Myocardial degeneration
Senility

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O S Lee M. D.
11/11 1914 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Nov 1914

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 9938
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Minidoka
City of Acequia
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Burlin Kehr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 10 (Day) 1914 (Year)

7. AGE ..... Yrs. 1 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Acequia

10. NAME OF FATHER Ira Kehr

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Aent Knox

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ira Kehr
(Address) .....

15. Filed 11/11 1914
O. H. Scott
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 2 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 31 1914, to Nov 2 1914, that I last saw h~~im~~ alive on Nov. 2 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

.....(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D B Kennedy M. D.
1914 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Nov 2 1914

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19

Primary Registration District No. .....

File No. 912

Registered No. .....

1. PLACE OF DEATH.

County of Minidoka

City of Rupert Ida.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Solomon D Sager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 19 (Day) 1837 (Year)

7. AGE: 78 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer, Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 12 years.

9. BIRTHPLACE (State or Country): Union Co.

10. NAME OF FATHER: Abraham Sager

11. BIRTHPLACE OF FATHER (State or Country): Union Co Ohio.

12. MAIDEN NAME OF MOTHER: Emeline Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ohio Morgan Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie M. Rhines.

(Address) Rupert Idaho.

15. Filed 11/13 1914

C. L. Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1914, to Nov 11 1914, that I last saw h= alive on Oct 20 1914, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder

(Duration) 3 Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Stevens, M. D.

11-12 1914 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert

DATE OF BURIAL: 11/13 1914

20. UNDERTAKER: J R Throckmorton

ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5. 10M: 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 923
Registered No. 6

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Nam Plymouth (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 2009

2. FULL NAME Ashton B Minaker

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 3 (Month) 1904 (Year)

7. AGE: 10 yrs. 9 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Ashton B. Minaker

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Alma Osbrander

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ashton B Minaker Talbo
(Address) Nam Plymouth Idaho

15.
Filed ..... 191...
Wm T. Dysedale
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9th 1914, to Sept 11 1914, that I last saw h... alive on Sept 10 1914, and that death occurred on the date stated above, at 1 pm.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. 9 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) William J. Reese M. D.
Oct 17 1914 (Address) Caldwell, Ore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nam Plymouth Idaho
DATE OF BURIAL: Sept 11 1914

20. UNDERTAKER: E E Snyder
ADDRESS: Nam Plymouth

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of New Plymouth
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. ; St.)

File No. 9239
Registered No. 5
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Olive Ora Nicholas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 20th of November 1877 (Month) (Day) (Year)

7. AGE: 35 yrs. 10 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Falls Town

10. NAME OF FATHER: C. M. Nichols

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ellen Barnes

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): C. M. Nichols
(Address): New Plymouth R R=2

15.
Filed ..... 191...
Wm T. Dysdale.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 8 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191..., to Sept 8 1914, that I last saw h er alive on Sept. 8 1914, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Cerebral Embolism with
Oedema of Lungs
(Duration) ..... yrs. Few hours mos. ..... ds.
Contributory (Secondary) Mitral stenosis
(Duration) many yrs. ..... mos. ..... ds.
(Signed) Wm T Dysdale M. D.
9-11 1914 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth — DATE OF BURIAL: Sept 11 1914

20. UNDERTAKER: A C Landers — ADDRESS: Payette Ida

EVENS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1045
File No. 92
Registered No.

1. PLACE OF DEATH.
County of Twin Falls,
City of [illegible]
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. T. Yeaman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: [illegible]
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec. 30 1866 (Month) (Day) (Year)

7. AGE: 48 yrs. 10 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: James Yeaman.

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Agnes Renwick

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Yeaman
(Address) Burley,

15. Filed 10-29 1914 John Keogh Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 29 1914
Jan 1 Jan 1 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1914, to Oct 29 1914, that I last saw h[illegible] alive on Oct 28 1914, and that death occurred on the date stated above, at 3A M.

The CAUSE OF DEATH* was as follows:
Perforating duodinal ulcer

(Duration) Not yrs [illegible] mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Oct 29 1914 (Add[illegible]) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 5 days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? Burley
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho
DATE OF BURIAL: 10-31 1914

20. UNDERTAKER: P. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls.
City of .....

Registration District No. 37
Primary Registration District No. 1037
(No. ....., ... St.)

File No. 9[illegible]
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Ogden Young

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1882 (Year)

7. AGE: 31 yrs. 9 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stone Mason
(b) General nature of industry business, or dstablishment in which employed (or employer): General

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: James Ogden Young

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Pearl Young.
(Address) Rock Creek Idaho

15.
Filed 10-30 1914
James T. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct (Month) 28th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to ..... 191...,
that I last saw h[illegible] alive on ..... 191...,
and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:
Coroner's Jury Verdict: Gun shot wound inflicted by himself.

.....(Duration).....yrs.....mos.....ds.

Contributory
(Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) E J Jensen Coroner M. D.
10 29 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 10-30 1914

20. UNDERTAKER: Chas. J. Cosby
ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 37
County of Twin Falls — Primary Registration District No. 1085
City of " " — (No. ....., ... St.)
File No. 92[illegible]
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Sears

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Nov. (Month) 22 (Day) 1834 (Year)

7. AGE: 79 yrs. 11 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: William Cambourn

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Barger
(Address) Twin Falls

15.
Filed 10-26 191[illegible] Johnson Coughe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. 24 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15 1914, to Oct. 25 1914, that I last saw h-er alive on Oct. 15 191[illegible] and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Olsen M. D.
Oct. 26 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Oct. 26 1914

20. UNDERTAKER: J. Sorensen — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 37
County of Twin Falls Primary Registration District No. 2085
City of ——— (No. ——— St.)
If death occurs away from usual residence, give facts called for under special information.
File No. 0[illegible]
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elberta A. Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Aug. (Month) 24 (Day) 1892 (Year)

7. AGE: 22 yrs. 1 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: A. J. Wright

11. BIRTHPLACE OF FATHER (State or Country): Utah Eng[illegible]land

12. MAIDEN NAME OF MOTHER: N. E. Harper

13. BIRTHPLACE OF MOTHER (State or Country): Utah Eng[illegible]land

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. J. Wright
(Address) Pleasant Grove Utah

15. Filed 10-15 1914 John D. Engle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1914, to Oct 14 1914, that I last saw h[illegible] alive on Oct 14 1914, and that death occurred on the date stated above, at 12.50 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 3 wk 3 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Frank A. Dwight M. D.
Oct 15 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 17 days. In the State Ida yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Near Hansen Ida.
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Pleasant Grove Utah
DATE OF BURIAL: Oct 18 1914
20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of [redacted]
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ....., ... St.)

File No. 9[illegible]
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel S. Hayes.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) (Year)

7. AGE: 20 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: S. S. Hayes.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nancy E. Fortney

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. T. Hayes
(Address) Ellensburg Wash

15. Filed Oct 9 1914 John F. Congleton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 8th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1914, to Oct 9 1914, that I last saw h[illegible] alive on Oct 9 1914, and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) ..... yrs. ..... mos. 18 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver, M. D.
10/8 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Ellensburg Wash | DATE OF BURIAL: 10-9 1914

20. UNDERTAKER: Chas J. Crowley | ADDRESS: Twin Falls Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 9216
Registered No. 43

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. Rose Station St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allan Pearson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 20 (Day) 1906 (Year)

7. AGE: 8 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: John Pearson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Jane Mc Gowan

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Pearson
(Address) Boise

15.
Filed 10-13 1914 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead 191 ~~to~~ date ~~191~~, that I last saw him alive on dead 10/11 1914, and that death occured on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:
Accidents being struck by an Automobile
Owned Boise Ada Co

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Adolph Schneider M. D.
19..... (Address) Boise Ada Co

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/13 1914

20. UNDERTAKER: Schreiber & Hiedemann — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 021

Registered No. 44

1. PLACE OF DEATH.

County of Ada

City of Boise.

(No. Lauberton, Add St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucinda E Parter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 27th (Day) 1853 (Year)

7. AGE: 61 Yrs. — Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Jesse Fuilder

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Mary McFarland

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. R. Porter

(Address) Boise

15. Filed 10-15 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 13th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11th 1914, to Oct 13 1914, that I last saw h[illegible] alive on Oct 13th 1914, and that death occured on the date stated above, at 9. P. M.

The CAUSE OF DEATH* was as follows:

Septic pneumonia

(Duration) Yrs. few days mos. ds.

Contributory (Secondary) Bronchial Asthma

(Duration many yrs. mos. ds.

(Signed) J. M. Taylor M. D.

Oct 13 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/15 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

File No. 9004

Registered No. 248

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel I Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 24 (Day) 1893 (Year)

7. AGE: 21 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Harvey L Bollinger

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) R Roy Smith

15. Filed 10-7 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 6th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27th 1914, to October 6th 1914, that I last saw her alive on Oct 6th 1914, and that death occured on the date stated above, at 5-15 P.M.

The CAUSE OF DEATH* was as follows:

Substernal Toxemia - Typhoid
or Bacillus Typhosus
(Autopsy showed lesions of ileum & enlarged mesenteric glands)
(Duration) Yrs. 1 mos. 13 ds.

Contributory (Secondary) —
(Duration ... yrs. ... mos. ... ds.

(Signed) J. M. Taylor M. D.

Oct 7 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 5 days In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? at residence

Former or usual residence 313 No 7th St. Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/8 1914

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1914
(No. 2016 Harrison Blvd.)

File No. 9249
Registered No. 279

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thora Mobley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. January 20 (Month) (Day) 1857 (Year)

7. AGE: 57 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Eugene, Oregon

10. NAME OF FATHER: Macey

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roberta Halsey
(Address) 1712 W. Bannock Boise

15. Filed 10-7 1914 — M S Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1906 to 1914, that I last saw h[illegible] alive on 10/5 1914, and that death occured on the date stated above, at 9:5 A M.
The CAUSE OF DEATH* was as follows: Hemiplegia Left Side.
(Duration) [illegible] Yrs. - mos. - ds.
Contributory (Secondary) Pneumonia-Broncho
(Duration - yrs. - mos. - ds.
(Signed) Fred A Tilden M. D.
10/7 1914 (Address) Gath Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pilgrim Cemetery — DATE OF BURIAL: 10/7 1914

20. UNDERTAKER: Schreiber & Sonnenberg — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. [illegible]
Registered No. 250

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 317 N. 13 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank P. King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. (Month) Mar (Day) 6 (Year) 1832
7. AGE: 62 Yrs. 7 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Penn
10. NAME OF FATHER Joseph King
11. BIRTHPLACE OF FATHER (State or Country) Penn
12. MAIDEN NAME OF MOTHER Mary Been
13. BIRTHPLACE OF MOTHER (State or Country) Penn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Mary B. King
(Address) Boise Idaho
15. Filed 10-8 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) oct (Day) 7 (Year) 1914
17. I HEREBY CERTIFY, That I attended deceased from oct 6 1914, to oct 7 1914, that I last saw h[illegible] alive on oct 7 1914, and that death occured on the date stated above, at 4 a[illegible] M.
The CAUSE OF DEATH* was as follows:
acute nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Myocarditis
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J S Sprague M. D.
oct 8 1914. (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 8 1914
20. UNDERTAKER: Ivy & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. Hultstrom

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 9251
Registered No. 251

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 81 Jukes Hwy St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Matilda Hultstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	White	Married

6. DATE OF BIRTH. May (Month) 13 (Day) 1838 (Year)

7. AGE 36 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Andrew Gardlitt

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John A Hultstrom
(Address) R.D. #2. Box 199 Boise

15.
Filed 10-10 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October (Month) 9th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1914, to Oct 9th 1914, that I last saw h.r alive on Oct 9th 1914, and that death occured on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:
Fecal peritonitis - following accidental rupture of abdominal incision after laparotomy
(Duration) — Yrs. — mos. 5 ds.
Contributory (Secondary) Had had hysterectomy Oct 2nd
(Duration yrs. mos. ds.

(Signed) J. M. Taylor M. D.
Oct 10 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. Hospital ...yrs. ...mos. 9 days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Oct 11 1914
20. UNDERTAKER Terry & Summers	ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 976

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 9258

Registered No. 252

County of Ada

City of Boise (No. 21 Jubilee Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H Sherrier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 30 (Day) 1861 (Year)

7. AGE: 51 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Road Master
(b) General nature of industry, business, or establishment in which employed (or employer): Proprietor

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: W. H. Sherrier

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Maggie Walker

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs W. H. Sherrier
(Address) Twin Springs Idaho

15. Filed 10-12 1914. M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1914, to Sept 20 1914, that I last saw h. alive on Oct 11 1914, and that death occured on the date stated above, at 3.30 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of face

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Wm Calvert M. D.

19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Oct 13 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 925

Registered No. 207

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Agoure

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1850 (Year)

7. AGE: About 64 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dioler M. Finton

(Address) Box

15. Filed 10 - 21 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 19th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1909, to Oct. 1914, that I last saw him alive on 18th Oct. 1914, and that death occured on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Four Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Dioler M. Finton M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. mos. 5 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Caldwell

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: Oct. 22 1914

20. UNDERTAKER: Schreiber & Kiddenfadden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada.

Primary Registration District No. 1004

City of Boise (No. St Lukes Hospital St.)

File No. 09

Registered No. 258

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James E. MacNamara.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. May 13 (Month) (Day) 1881 (Year)

7. AGE: 33 Yrs. 5 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: John Douglas.

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Ella Nixon

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. MacNamara

(Address) Bliss, Idaho

15. Filed 10-21 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1914, to Oct 20 1914, that I last saw h[illegible] alive on Oct 20 1914, and that death occured on the date stated above, at 1 4 M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M B Smith M. D.

Oct 24 19 14 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Bliss Idaho.

19. PLACE OF BURIAL OR REMOVAL: Owens Iowa. DATE OF BURIAL: Oct 24 1914

20. UNDERTAKER: Fry & Summers. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 927

Registered No. 259

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District, No. 4 or 4

County of Ada

City of Boise (No. 1001 W. Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel K. Behrand

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. June (Month) 6 (Day) 1857 (Year)

7. AGE: 57 Yrs. 4 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining Promoter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn. Ills.

10. NAME OF FATHER: P. K. Behrand.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Margt Pinttand

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. A. Behrand
(Address) 1012 State St. Boise

15. Filed 10 – 22 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1914, to Oct 20 1914, that I last saw him alive on Oct 20 1914, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
complicated by Enlarged Heart.
(Duration) 2 Yrs. 6 mos. ds.

Contributory (Secondary) Enlarged Heart
(Duration) yrs. mos. ds.

(Signed) Chas. B Callard M. D.
19 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs. 1 mos. ..days. In the State ..yrs. ..mos. ..days
Where was disease contracted if not at place of death?
Former or usual residence Baltimore Md.

19. PLACE OF BURIAL OR REMOVAL: Washington D. C. DATE OF BURIAL: Oct 23rd 1914

20. UNDERTAKER: Schreiber & Heidenfeldt ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Dr. Callard

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 9256
Registered No. 260

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 1413 Hays St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John G. Strawman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 17 (Month) (Day) 1838 (Year)

7. AGE: 76 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling
(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Henry Strawman

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna E. Strawman
(Address) 1415 Hays -

15. Filed 10-22 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1914, to Oct 21 1914, that I last saw him alive on Oct 20 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. B. Faucett M. D.

10/22/1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Boise Idg

19. PLACE OF BURIAL OR REMOVAL: Morris Hill - DATE OF BURIAL: 10/23 1914

20. UNDERTAKER: Terry & Summers ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 925
Registered No. 262

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1004

(No. Cor 1st & Michigan Ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Mar (Month) 5th (Day) 1855 (Year)

7. AGE: 59 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas City, Mo.

10. NAME OF FATHER: Caleb D Richards

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alice Dike
(Address)

15. Filed 10-24 1914 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23rd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23rd 1914, to Oct 24th 1914, that I last saw him alive on Oct 23d 1914, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy — cerebral Hemorrhage

(Duration) Instant Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Boeck M. D.

19 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence So. Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: 10/26 1914

20. UNDERTAKER: Schreuber & Siebenfaden — ADDRESS: Boise

Dr. Boeck & Nagler

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1009
File No. (illegible)
Registered No. 263

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. St. St. Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances J Crowe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 20 (Day) 1914 (Year)

7. AGE — Yrs. — Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ft Lisk Ida

10. NAME OF FATHER: J. J Crowe

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Jinnie Wortz

13. BIRTHPLACE OF MOTHER (State or Country): Boise Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. J. Crowe
(Address) Boise, Idaho.

15. Filed 10-26 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 25th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20th 1914, to Oct 25th 1914, that I last saw him alive on Oct 25th 1914, and that death occured on the date stated above, at 12.40 P M.

The CAUSE OF DEATH* was as follows:
Unknown - Sudden pain & cramping followed by Marked cyanosis & respiration gradually failed - ill 36½ hours (Duration) - Autopsy showed nothing Yrs. mos. ds.
Contributory (Secondary) Unknown - Assumed a perfectly normal infant -
(Duration) yrs. mos. ds.
(Signed) J. M. Taylor M. D.
19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 26 1914

20. UNDERTAKER: Terry & Summers — ADDRESS: Boise Idaho

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 416 Jefferson St.)

Registration District No.

Primary Registration District No. 1004

File No. 921

Registered No. 264

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Perrault

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 25 (Month) (Day) 1914 (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many....hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business, or establishment in which employed (or employer)....

none

9. BIRTHPLACE (State or Country) Boise

10. NAME OF FATHER Jos Perrault Jr

11. BIRTHPLACE OF FATHER (State or Country) Boise

12. MAIDEN NAME OF MOTHER Edythe Emery

13. BIRTHPLACE OF MOTHER (State or Country) Montana Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Perrault Jr

(Address) Boise Idaho

15. Filed 10-26 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1914 to 1914, that I last saw h in alive on Oct 25 1914, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows: Premature birth 5 1/2 Mos

Lived about 30 minutes

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration ....yrs. ....mos. ....ds.

(Signed) M O Smith M. D.

10/25 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 10/26 1914

20. UNDERTAKER: Schreiber & Kiddoo — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 9264
Registered No. 265

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1604 N. 13th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Addison Lee Ewing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov 3rd 1837 (Month) (Day) (Year)

7. AGE: 76 Yrs. 11 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): New Albany, Ohio

10. NAME OF FATHER: not Obtainable

11. BIRTHPLACE OF FATHER: not Obtainable (State or Country)

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER: not Obtainable (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. L. Ewing
(Address) Boise Ida.

15. Filed 10-26, 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 25th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-2 1914, to 10-25 1914, that I last saw h[illegible] alive on 10-24 1914, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of bile passages
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Maurice H. Fellman M. D.
10/26 1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Boise Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 10/27 1914

20. UNDERTAKER: Schroeder & Sidenfaden | ADDRESS: Boise.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 410 State St.)

File No. 9265

Registered No. 266

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elida A. W. Morgan - Louise

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 6th (Day) 1869 (Year)

7. AGE: 44 Yrs. 10 Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Wm Miller

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Agustus morgan
(Address)

15. Filed 10-26 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 7.A. M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Obstruction of bowels

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Sprague M. D.

Oct 22 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Bliss

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/27 1914

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

F... V. S. No. 5-... M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
(No. ..... , ... St.)

File No. 9263
Registered No. 246

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hugh Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not Obtainable (Month) (Day) 186 (Year)

7. AGE: 48 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: T. Martin

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Sarah Martin
(Address) Boise Idaho

15.
Filed 10-5 1914
Robt D Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 3d (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd 1914, to Oct 2nd 1914, that I last saw h. im alive on Sep. 25th 1914, and that death occured on the date stated above, at 10.30 P. M.

The CAUSE OF DEATH* was as follows:
Angina pectoris
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Hypertrophied Heart
(Duration) ... yrs. ... mos. ... ds.

(Signed) John Baer M. D.
Oct 3 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 5 1914

20. UNDERTAKER: Jay & Summers — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & SOBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Canyon

Primary Registration District No. 7004

File No. 9264

City of Nampa (No. 11 Ave South St.)

Registered No. 256

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Church Orr.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April 29 (Month) 1891 (Day) (Year)

7. AGE: 23 yrs. 5 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: Geo. F Church.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Lillian Baynes

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S B Shellabarger
(Address) Nampa Idaho

15. Filed 10 - 16 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Oct 14 1914, that I last saw her alive on Oct 14 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Rose M. D.

Oct 15 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem Boise, Ida — DATE OF BURIAL: Oct 16 1914

20. UNDERTAKER: S. B. Shellabarger. — ADDRESS: Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

[redacted] S. No. 5-36 M. 1-16-13

[redacted] ACE OF DEATH.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11

Primary Registration District No. 2003

File No. 9265

Registered No. ____

County of Ada

City of Boise (No. [redacted] St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H. Waits

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 12 (Day) 1842 (Year)

7. AGE: 72 Yrs. ... Mos. 23 ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: David Waits

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Francis Kreps

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [redacted]
(Address) [redacted]

15. Filed Oct 6 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 24 1914, to Oct 5 1914, that I last saw h[redacted] alive on Oct 4 1914, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Asthma & Complications

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ____

(Duration ... yrs. ... mos. ... ds.

(Signed) L. L. Bowman M. D.

19... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Oct. 8 1914

20. [redacted] ER — ADDRESS [redacted] Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24853

FORM — S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2003

File No. 9266

County of Ada

City of ~~—~~ (No.) near McMillen Chapel

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isham Joplin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Mar (Month) 10 (Day) 1827 (Year)

7. AGE: 87 Yrs. 7 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): W. Va.

10. NAME OF FATHER: Thos. Joplin

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: Patsis Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Silas M. Joplin
(Address)

15. Filed Nov. 4th 1914 — C. L. Button, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 4th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Oct 27th~~ 1914, to Nov 4th 1914, that I last saw him alive on Oct 3rd 1914 and that death occured on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. L. Button M. D.

19.... (Address)

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Joplin Cemetery	11/4 1914
20. UNDERTAKER	ADDRESS
Schreiber & Siedenfaden	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & SORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 921
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira Leste Kaaon.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 10th (Day) 1914 (Year)

7. AGE: — yrs. — mos. 24 ds. IF LESS than 1 day how many .. hrs. or .. mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) St Lukes Hospital Boise

10. NAME OF FATHER Paul L. Kaaon.

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Anna Hunnicutt

13. BIRTHPLACE OF MOTHER (State or Country) Texas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. L. Kaaon
(Address) Meridian Idaho

15. Filed Sept 4 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1914, to Sept 4th 1914, that I last saw him alive on Sept 4 1914, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia (acute)
Acute Broncho Pneumonia

(Duration) yrs. mos. 12 hours

Contributory (Secondary) Mother had La Grippe

(Duration) yrs. mos. 2 ds.

(Signed) C. L. Dutton M. D.
10/4 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .. yrs .. mos .. days. In the State .. yrs .. mos .. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Cemetery	10-4th 1914

20. UNDERTAKER	ADDRESS
J. M. Anderson acting undertaker	Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 926
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special *information*.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Clarissa L. King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Feb 4 1914 (Month) (Day) (Year)

7. AGE: yrs. 7 mos. 18 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *min.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Meridian Idaho

10. NAME OF FATHER: Webster L King

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Cora L Bickford

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Neal
(Address) Meridian

15. Filed Oct 5th 1914 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 4 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1914, to Oct 4 1914 that I last saw her alive on Oct 4 1914, and that death occurred on the date stated above, at 11.45 P. M.

The CAUSE OF DEATH* was as follows:
Enteric Colitis (acute)

(Duration) ..... yrs. ..... mos. 21 ds.
Contributory (Secondary) Exhaustion
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. F. Neal M. D.
Oct 5 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 191

20. UNDERTAKER: Webster L King — ADDRESS: Oct.
Acting Undertaker.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1002
(No. 221 W. Spring St.)
File No.
Registered No. 291

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James C. Baldwin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 10 (Day) 1829 (Year)

7. AGE: 85 yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: J. Baldwin

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Hannah Knapp

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Tillie Baldwin
(Address): Star Idaho

15.
Filed 12-3 1914
M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25th 1914, to Nov. 27th 1914 that I last saw him alive on Nov. 26th 1914 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Dyspepsia, Senility.

4 da. (Duration) ___ yrs. ___ mos. ___ ds.
Contributory (Secondary) Pneumonia
1 wk. (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. F. Kramer M. D.
Nov 27 1914 (Address) 212 Main St. Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Star 24 years.

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: Dec 3 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [redacted]
Registered No. 22

Registration District No. 12
Primary Registration District No.
(No. 2019 St.)

1. PLACE OF DEATH.
County of Pearl
City of Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Van Horton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 8 (Day) 1861 (Year)

7. AGE 53 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: A. J. Drake

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Luella May Drake

13. BIRTHPLACE OF MOTHER (State or Country): Ohio (?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bessie Van Horton
(Address) Pearl Idaho

15. Filed Dec 1914 Mary Fitch Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1911 [illegible], to Nov 1914, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pregnancy complicated by Bronx
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) James L Elwood M. D.
19... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pearl Ida — DATE OF BURIAL: Nov. 21 1914

20. UNDERTAKER: Buckman — ADDRESS: Emmett.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9211
Registered No. 83

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 92
Primary Registration District No. 10019
(No. Pullman Lewiston Pike St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mable Ford (assumed) maiden name

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: April (Month) 27 (Day) 1886 (Year)

7. AGE: 28 yrs. 6 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Prostitute
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Gabe Paul

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Martha Evans

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C T Straughan
(Address) Earl-Lewiston

15.
Filed Dec. 10 - 1914 L J Parkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1914., to Nov 10 1914
that I last saw her alive on Nov 10 1914
and that death occurred on the date stated above, at 4 a M.
The CAUSE OF DEATH* was as follows:
Septicemia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. T. Straughan M. D.
Nov 10 1914 (Address) Supt County Hosp.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death County Hospital In the Lewiston
..... yrs. ..... mos. 5 ds. State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 11/12 1914

20. UNDERTAKER: C J Vassar
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [redacted]
Registered No. 27

1. PLACE OF DEATH.
County of Nez Perce.
City of Lewiston.
Registration District No. 5 96
Primary Registration District No. 1009
(No. ..... Poon Barn St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Abbott

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: November Third 1844
(Month) (Day) (Year)
7. AGE: 69 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Tinsmith
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): England.
10. NAME OF FATHER: John Abbott.
11. BIRTHPLACE OF FATHER (State or Country): England.
12. MAIDEN NAME OF MOTHER: Ellen Bain.
13. BIRTHPLACE OF MOTHER (State or Country): England.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. T. Strawhun
(Address) Lewiston
15.
Filed Dec. 10- 1914 L. C. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November Fourth 1914
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1914, to Nov 4 1914, that I last saw h[redacted] alive on Nov 3 1914, and that death occurred on the date stated above at 3 P M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
..... (Duration) 1 yrs. 9 mos. ... ds.
Contributory (Secondary) Cold.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. T. Strawhun M. D.
..... 19..... (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: [redacted] 1914

20. UNDERTAKER: J. Vassar
ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1809

(No. St. Joseph Hospital St.)

File No. [illegible]

Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Morcus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 10 (Day) 1 (Year)

7. AGE: 34 Yrs. ..... Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bridge Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: John Morcus

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Katrena Buscht

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Rt 1 Marcus

15. Box 323 Lewiston Ida

Filed Dec 10 1914 L. P. Perkins Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1914, to Nov 5 1914, that I last saw him alive on Nov , 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Gun Shot wound

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Morris M. D.

1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wakeosha Wisc. DATE OF BURIAL: 191

20. UNDERTAKER: C. Hassar ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9E
Primary Registration District No. 1009
(No. ....., ... St.)

File No. 994
Registered No. 99

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harmon Ives Bennett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 2 (Day) 1852 (Year)

7. AGE: 62 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerical work
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: H. Bennett

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Vosburg

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary S. Bennett
(Address) Lewiston Idaho

15.
Filed Dec. 10. 1914 R. O. Peters Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1914, to Nov 3 1914, that I last saw h.. alive on Nov 3 1914, and that death occured on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage
(Apoplexy)
Hemiplegia - (right) 20 hours
(Duration) Yrs. mos. ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) Unknown - yrs. mos. ds.
(Signed) Edgar P. White M. D.
Nov 5 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 11/6 1914

20. UNDERTAKER: Lenan
ADDRESS: Lewiston

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9275
Registered No. 30

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virgil Blackburn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 10th (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Idaho

10. NAME OF FATHER: Gordon Blackburn

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Bessie Allen

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Dec 10 – 1914 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3rd 1914, to Nov 7th 1914, that I last saw h.. alive on Nov 7th 1914 and that death occurred on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

..... (Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Artificial feeding
..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) O. C. Carson M. D.
Nov 8th 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Gordon Blackburn
ADDRESS: 1245 Idaho St Lewiston
Father of Child

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. ....., ... St.)

File No. 1 [illegible]
Registered No. 81
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ben Peach

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Dont Know (Month) 1 (Day) (Year)

7. AGE
45 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Kress
(Address) Juliaetta Ida

15.
Filed Dec 10- 1914 L C Reeves
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov- 7 1914, to Nov 9 1914, that I last saw h[illegible] alive on Nov 7 1914, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Diabetic Coma 3
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Diabetes 7
(Duration) ..... mos. ..... ds.
(Signed) John T. Hoyt M. D.
11-9 1914 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lapwai	Nov 10 1914

20. UNDERTAKER	ADDRESS
C J Wasson	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 1009
File No. 9274
Registered No. 32

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ..... Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Anna Bowen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 31 (Day) 1879 (Year)

7. AGE: 35 Yrs. — Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: John Nolon

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Bowen

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Bowen
(Address) Lewiston Idaho

15. Filed Dec. 10 — 1914 — C J Bassar Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 9th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3rd 1914, to Nov. 9th 1914, that I last saw her alive on Nov. 9th 1914, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Cirrhosis B liver
one week
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration — yrs. — mos. — ds.
(Signed) C. Sampson M. D.
11/10 1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Nov 10 1914

20. UNDERTAKER: C J Bassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 9258
Registered No. 34

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis S. Larson - Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Nov (Month) 11 (Day) 1914 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or 10 min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... X
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Lewiston
10. NAME OF FATHER Lewis S Larson
11. BIRTHPLACE OF FATHER (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Amanda Hahan
13. BIRTHPLACE OF MOTHER (State or Country) Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Louie S Larson
(Address) Lewiston Ida
15. Filed Dec 10 1914 E J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 11 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1914, to Nov 11 1914, that I last saw him alive on Nov 11 1914, and that death occured on the date stated above, at 1:10 P.M.
The CAUSE OF DEATH* was as follows:
Unknown.
..... (Duration) ..... Yrs. ..... mos. 10 Min ds.
Contributory (Secondary) Unknown.
..... (Duration) ..... yrs. ..... mos. 10 min ds.
(Signed) Edgar L White M. D.
11/11 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Nov 11 1914
20. UNDERTAKER: E J Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 1 [illegible]
Registered No. 35

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 316 3rd ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Manning Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Jan (Day) 21 (Year) 1890

7. AGE: 24 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Sailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lewiston

10. NAME OF FATHER Fred Manning

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Emma M. Crone

13. BIRTHPLACE OF MOTHER (State or Country) Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Bain
(Address) Lewiston Idaho

15. Filed Dec 10 1914 R. J. Perkins Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Nov 11 1914, that I last saw h. was alive on Nov 11 1914 and that death occured on the date stated above, at 11 30 P. M.

The CAUSE OF DEATH* was as follows:
General Tuberculosis

(Duration) 1 Yrs. 8 mos. — ds.

Contributory (Secondary) Same
(Duration) same yrs. same mos. ds.

(Signed) Edgar L. White M. D.
11-13 1914 (Address) Lewiston 2 da

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 12/14/1914

20. UNDERTAKER: [illegible] Sasser — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of .....

City of .....

(No. 0123 1st. St.)

Registration District No. 96

Primary Registration District No. 1009

File No. 1 9250

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christ Wiesgerber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH. Sept (Month) 11 (Day) 48 (Year)

7. AGE 66 Yrs. 2 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Philip Wiesgerber

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Philip Wiesgerber
(Address) .....

15. Filed Dec 10 1914 S. G. Benton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Nov 15 1914, that I last saw h[illegible] alive on Nov 15 1914, and that death occured on the date stated above, at 4 A. M.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Hyatt M. D.
1914 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	11/23 1914
20. UNDERTAKER	ADDRESS
J. Clarson	Lewiston

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-2b M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 1 9291
Registered No. 97

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 0128, 8th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm J Doyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 1 (Day) 1842 (Year)

7. AGE: 72 Yrs. 5 Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Tom Doyle

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Doyle
(Address) 0128 8th St.

15. Filed Dec 19 1914 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 22 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 191 4, to Nov 22nd 191 4, that I last saw h[illegible] alive on Nov 8th 191 4 and that death occured on the date stated above, at 10 10 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) P. C. Isaacson M. D.

19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston 2 — DATE OF BURIAL: 11/24 1914

20. UNDERTAKER: Hasse — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5. 10M. 6-26-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9257
Registered No.

1. PLACE OF DEATH.
County of Boise
City of Horseshoe Bend Ida
(No. ....., ... St.)
Registration District No. 6
Primary Registration District No. 2626

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willie Moore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Dec. (Month) 28 (Day) 1883 (Year)

7. AGE: 30 yrs. 10 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Co Oregon

10. NAME OF FATHER: William M. Moore

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Alvira Huntley

13. BIRTHPLACE OF MOTHER (State or Country): Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alvira Dumond
(Address) Horseshoe Bend Ida.

15.
Filed 1914
A. G. Byrd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1914, to Nov 3 1914, that I last saw him alive on Nov 3 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Myocardial insufficiency

(Duration) Several yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R A Cummings M. D.
12/5 1914 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

A. G. Byrd moved away from town

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 84

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.

Primary Registration District No. 2161

File No. 9283 6

Registered No. 247

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. R.R. Yards St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Walsh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Abt 1 (Month) (Day) (Year)

7. AGE 30 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O J Neely Coroner

(Address) Pocatello Idaho

15. Filed Oct 31 1914 O J Neely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 30 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

R R Accident
Run over

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration 8 yrs. ... mos. ... ds.

(Signed) O J Neely Coroner M. D.

10-31-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lenhartt Colo. DATE OF BURIAL ... 191...

20. UNDERTAKER: Wallace & Mann. ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 84 9285

Primary Registration District No. 2161

State of Ida[illegible] BOARD OF H[illegible] Bureau of Vital [illegible]tics

File No. 6 [illegible]

Registered No. 245

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) 1 (Day) ..... 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Oct 29 1914 O P Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about Oct (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: found dead near Post Office Station - Suicide pistol shot.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O P Steely Coroner M. D.

Oct 30, 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery | DATE OF BURIAL: Oct 29 1914

20. UNDERTAKER: Wallace & Mann | ADDRESS: Pocatello Ida

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

Residence 1122 S 9th Av.

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9286

Registered No. 244

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

2. FULL NAME Donald Edmar Woolsey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 19 (Month) (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Frank Woolsey

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Dell Barker

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Woolsey

(Address) Pocatello, Idaho

15. Filed Oct 24 1914

O B Treacy
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

Newton

16. DATE OF DEATH: Oct (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1914, to Oct 24 1914, that I last saw h~~im~~ alive on Oct 24 1914, and that death occured on the date stated above, at 2'30 P M.

The CAUSE OF DEATH* was as follows:

Premature birth maldevelopment and marasmus

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Newton M. D.

Oct 24 1914 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby, Idaho — DATE OF BURIAL ..... 191..

20. UNDERTAKER: Wallace & Mann. — ADDRESS Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 5250 5

Registered No. 236

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. ..., East Center St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maude Viglini Varley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. July (Month) 18 (Day) 1890 (Year)

7. AGE: 24 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm E. Viglini

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Miss Addie Simkins

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Alice Tingley

(Address) Salt Lake City, Utah

15. Filed Oct 2 1914 O B Tingley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Homicide - Shot

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) O B Tingley Coroner M. D.

19... (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah

DATE OF BURIAL: ... 191...

20. UNDERTAKER: Wallace & Mann

ADDRESS: Pocatello Idaho

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9285

Registered No. 237

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. 734 E. Center St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard W. Varley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~

6. DATE OF BIRTH. May (Month) 8 (Day) 1884 (Year)

7. AGE: 30 Yrs. 4 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Jas. Varley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary H. Fairbrother

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Varley

(Address) Ogden, Utah.

15. Filed Oct 2 – 1914 O B Lucky Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suicide
Shot in head

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) O B Lucky Coroner M. D.

10-2- 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Walker & Dann — ADDRESS: Pocatello, Idaho

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 84

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No. 2161
File No. 3289
Registered No. 238

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allen Duncan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 11 (Day) 1912 (Year)

7. AGE: 2 Yrs. 5 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward J. Duncan

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Ruth V. Grow

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Geo Gordon
(Address) Pocatello, Idaho

15. Filed Oct 9th 1914
O B Steedy
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1914, to Oct 9 1914, that I last saw him alive on Oct 9 1914, and that death occured on the date stated above, at 1:30 a M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart

(Duration) ..... Yrs. ..... mos. Several ds.
Contributory (Secondary) Croup and bronchitis with old heart lesion
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr A M Newton M. D.
Oct 9 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah
DATE OF BURIAL: Oct 10 1914

20. UNDERTAKER: Wallace & Sawn
ADDRESS: Pocatello, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Newton M.D.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9290 5

Registered No. 239

Registration District No. 84

Primary Registration District No. 2161

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. 709, South 3rd St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delora Elizabeth Workman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 12 (Day) 1914 (Year)

7. AGE: Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. S. Workman

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Effie Ross

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. S. Workman

(Address) Pocatello

15. Filed Oct 9th 1914 O. B. Neely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1914, to Oct 9 1914, that I last saw h[illegible] alive on Oct 8 1914, and that death occured on the date stated above, at 9:30a M.

The CAUSE OF DEATH* was as follows:

Enteritis.

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary): Marasmus Malnutrition

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Newton M. D.

Oct 9 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Idaho. DATE OF BURIAL: Oct 10 1914

20. UNDERTAKER: Wallace & Wann. ADDRESS: Pocatello, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 84

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(No. ....., ... St.)

Registration District No. .....
Primary Registration District No. 2161

File No. 9291 5

Registered No. 240

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Laborer

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Oct 14 1914

O B Stacy
Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Homicide - gun shot wound through heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O B Stacy Coroner M. D.

10-14-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Oct 18 1914

20. UNDERTAKER: Wallace & Wann — ADDRESS: Pocatello, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 504

Registered No. 243

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 156 S. Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold William Kimball

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 17 (Month) (Day) 1908 (Year)

7. AGE: 6 Yrs. 7 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan Utah

10. NAME OF FATHER: W. W. Kimball

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lottie Goodwin

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. M. Shields

(Address) 156 Main st

15. Filed Oct 23d 1914

E. Neely
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1914, to Oct. 22 1914, that I last saw him alive on Oct. 22 1914, and that death occured on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull.

(Duration) ..... Yrs. ..... mos. 18 hours

Contributory (Secondary): Pulmonary Edema.

(Duration ..... yrs. ..... mos. 6 hours.

(Signed) F. M. Sprague M. D.

10. 23 1914 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cemetery — DATE OF BURIAL: 191

20. UNDERTAKER: Crawford & Schuneman — ADDRESS: Pocatello

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. S. 9295
Registered No. 220

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 609, South 7th. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorbi Volpi

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1913 (Year)

7. AGE: ——— yrs. 9 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: ———
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brigham Utah

10. NAME OF FATHER: Joe Volpi

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Rosa Ferrari

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Joe Volpi
(Address) Pocatello

15.
Filed Aug 14, 1914 O B Beasley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10th 1914, to Aug 13 1914, that I last saw h in alive on Aug 12 1914, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Enteric Colitis

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O B Beasley M. D.
Aug 14 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Aug 14 1914

20. UNDERTAKER: Wallace & Jann — ADDRESS: Pocatello Idaho

BYRNE-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 5 9296
Registered No. 231

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 210, 11-1st Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Steve Wm Paris

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Greek
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1913 (Year)

7. AGE: — yrs. 9 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: John Paris

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Annie Marquintah

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Paris
(Address):

15. Filed Sept 2 1914 O P Stacey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1914, to Sept 1 1914 that I last saw he ~~r~~ alive on Sept 1 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Sept 2 1914 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds
In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery
DATE OF BURIAL: Sept 3 1914

20. UNDERTAKER: Wallace & Dunn
ADDRESS: Pocatello

BYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 51. 9295

Registered No. 222

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 144 S. Second St.)

Registration District No. 84

Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert J. McIntosh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 19 (Day) 1895 (Year)

7. AGE: 19 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer): Man

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Chas M. McIntosh

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Rachael Bell

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rachel E McIntosh

(Address) Dillon Mont

15. Filed Sept 5, 1914 — O F Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
Sept 4, 1914

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O F Hunt Coroner M. D.

9-5-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dillon Mont — DATE OF BURIAL: Sept 7 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 442, E. Hayden St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161

File No. 15928
Registered No. 223
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gaetano Gianchetta

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Apr 25 1914 (Month) (Day) (Year)

7. AGE: yrs. 4 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bannock Co.

10. NAME OF FATHER: Joe Gianchetta

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Caterina D'Agnilli

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Gianchetta
(Address) 442 E. Hayden St.

15. Filed Sept 5 1914 Sept 5 P B Sims Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 5 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1914, to Sept 5 1914, that I last saw her alive on Sept 5th 1914, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Enteric Colitis

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O B Sims M. D.
Sept 5 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery | DATE OF BURIAL: 9/6 1914

20. UNDERTAKER: Wallace & Sons | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(No. 808, South 2nd Ave St.)

Registration District No. 84
Primary Registration District No. 2161

File No. 5[illegible] 9229
Registered No. 224

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Violet Hoffman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. March (Month) 26 (Day) 1871 (Year)

7. AGE: 43 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James W. Steed

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Violet Richardson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): A Allred

(Address): Jackson Idaho.

15. Filed Sept 8 1914

O B Riley
Local Registrar

BYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to Sept 6 1914, that I last saw h[illegible] alive on Sep 5 1914, and that death occured on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency with Broken Compensation

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary): Influenza

(Duration) yrs. 6 mos. ds.

(Signed) Dr A M Newton M. D.

Sept 8 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt. View Cemetary

DATE OF BURIAL: 191

20. UNDERTAKER: Wallace & Wann

ADDRESS: Pocatello. Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Newton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15930

Registered No. 228

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Jane Cottle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Oct 14 (Month) (Day) 1845 (Year)

7. AGE: 68 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Marcus B Allen

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. W. Cottle

(Address) 455 S Main

15. Filed Sept 7, 1914 — O B Treesy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1912, to Sept 6 1914, that I last saw h[illegible] alive on Sept 6 1914, and that death occured on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastasis into liver and stomach

(Duration) 2 Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr A. M. Newton M. D.

Sept 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 9 1914

20. UNDERTAKER: Crawford & Schumacher — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 15930

County of Bannock

City of Pocatello (No. 519 E. Lyon St.)

Registered No. 226

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas. Zaccardi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 2 (Day) 1913 (Year)

7. AGE: 1 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Jas. C. Zaccardi

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Josephine Meriano

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. P. Zaccardi

(Address) Pocatello Ida.

15. Filed Sept 11 1914

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1914, to Sept 10th 1914, that I last saw him alive on Sept 9th 1914, and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) Gastro-Enteritis

(Duration) yrs. mos. 30 ds.

(Signed) F. M. Sprague M. D.

9-11 1914 (Address) Bannock Block

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Sept 11 1914

20. UNDERTAKER: Wallace & Sons — ADDRESS: Pocatello, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Dr Steely

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. 457 S. Arthur St.)

File No. 9302
Registered No. 227

1. PLACE OF DEATH.
County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Dunn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
June 17 (Month) (Day) 1907 (Year)

7. AGE
7 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Pocatello

10. NAME OF FATHER
John Dunn

11. BIRTHPLACE OF FATHER
(State or Country) New York

12. MAIDEN NAME OF MOTHER
Mary White

13. BIRTHPLACE OF MOTHER
(State or Country) Glascow Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary West Parkes
(Address) Pocatello

15.
Filed Sept 11 1914
Local Registrar

BYNS - YORK CO. PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept 10th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26th 1914, to Sept 10th 1914, that I last saw her alive on Sept 9th 1914, and that death occured on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:
Carcinoma following appendicitis
(Duration) Yrs. mos. 14 ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) O. B. Steely M. D.
9-11-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Sept 11 1914

20. UNDERTAKER: Wallace & Dunn — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5303

Registered No. 228

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. Gen Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mable Britton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. April (Month) 3 (Day) 1899 (Year)

7. AGE: 15 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montrose Colo

10. NAME OF FATHER: Theadore Britton

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Florence Martin

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Theodore Britton
(Address) Downey Ida.

15. Filed Sep 13, 1914 — O F Steele, Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 PM Sept (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1914, to Sept 13 1914, that I last saw h[illegible] alive on Sept 13 1914, and that death occured on the date stated above, at 2:00 P M.

The CAUSE OF DEATH* was as follows:
General peritonitis following appendicitis

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Dr A M Burton M. D.

Sept 13 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey Ida — DATE OF BURIAL: Sept 15 1914

UNDERTAKER: Crawford & Schumacher — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9394 8

Registered No. 229

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. C. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. M. Woods

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

No information Obtainable

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Sept 16 1914

O. Keely
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Sept 14 1914, that I last saw him alive on Sept 14 1914, and that death occured on the date stated above, at 4:30 a M.

The CAUSE OF DEATH* was as follows:

Subacute endocarditis with mitral lesion and broken compensation.

(Duration) Yrs. 2 mos. ..... ds.

Contributory (Secondary) Colitis

(Duration yrs. 1 mos. 10 ds.

(Signed) Dr A M Newton M. D.

9/16 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Sept 16 1914

20. UNDERTAKER: Wallace & Wann — ADDRESS: [illegible]

SYMS - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 9305 8
Registered No. 230

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 947 W Clark St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susan Mitchell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept 17 (Month) (Day) 1714 (Year)

7. AGE: 3 hours
Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chief
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: S. L. Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Cal

12. MAIDEN NAME OF MOTHER: Alice Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Calo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. L. Mitchell
(Address) Pocatello Idaho

15. Filed Sept 19 1914 O. P. Keeley Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 18 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Non Closure of
foramen ovale
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) O. P. Keeley M. D.
9-18-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 18 1914.
20. UNDERTAKER: Crawford & Schumacher — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9306 s

Registered No. 231

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 754 ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Sept 23 1914 O. P. Steely Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. ..... (Month) ..... (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191, to ..... 191, that I last saw h alive on ..... 191, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found dead in box car on R R

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. P. Steely Coroner M. D.

9-23-1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 9-23 1914

20. UNDERTAKER: Wallace Wesen — ADDRESS: Pocatello, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9307 S

Registered No. 232

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 354 South 2nd St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Manuel Osolo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Spanish

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 4 (Day) 1913 (Year)

7. AGE ..... Yrs. 9 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ed. Osolo

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER Santa Datica

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Osolo

(Address) Pocatello Idaho

15. Filed Sept 26 1914

O. D. Keely
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 27 1914, to Aug. 29 1914, that I last saw h[im] alive on Aug. 29 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Marasmus

Senile Debility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

9/26 1914 (Signed) E. Roberts M. D.

(Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Sep 26 1914

20. UNDERTAKER: Wallace Warner — ADDRESS: Pocatello, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. Roberts

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. 644 S. Harrison St.)

File No. 9308

Registered No. 233

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Calisto Abadia

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Exact date unknown. (Month) 1866 (Day) 1 (Year)

7. AGE: near as known. 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: John Abadia

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Maria Abadia

13. BIRTHPLACE OF MOTHER (State or Country): Vizcaya

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Manuel Benguetxea

(Address) 604 So Harrison

15.

Filed Sept 27, 1914

O. B. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 26 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 15 1914, to ..... 191..., that I last saw h in alive on that date 191..., and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver

(Duration) — Yrs. 6 mos. — ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) O. B. Roberts M. D.

7/27 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View	Sept 28 1914

20. UNDERTAKER	ADDRESS
Crawford and Schumacher	Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 216

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9309 5

Registered No. 234

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. 419 S Garfield St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Peirce

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 15 (Day) 1853 (Year)

7. AGE 61 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William Peirce

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Barnett

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. P. C. Murphy
(Address) 419 S Garfield

15. Filed Sept 30 1914 — O B Lucy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1914, to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Sudden death
- Apoplexy.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O B Lucy M. D.

9-24-1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 30 1914

20. UNDERTAKER: Crawford & Schumacher — ADDRESS: City

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

9444

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 93105

Registered No. 235

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Village of Arimo (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Trifon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Greek

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1864 (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Cacavas

(Address) S. Bris[illegible]

15. Filed Sept 30 1914

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 29th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: R. R. accident

(Struck by locomotive

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Stacy Conner M. D.

9-30 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sale[illegible]

DATE OF BURIAL: Sept 30 1914

20. UNDERTAKER: Crawford & Schumacher

ADDRESS: City

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 9311
Registered No. 23

2. FULL NAME Annie Buchman
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 26 (Day) 1914 (Year)

7. AGE: — yrs. — mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carl Buchman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Annie Puffal

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Buchman
(Address) Payette Ida

15. Filed Nov. 10 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1914, to Nov 10 1914, that I last saw her alive on Sept 30 1914, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Inherited Lues

(Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
11-11 1914 (Address) Payette

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette — DATE OF BURIAL: Nov 11 1914

20. UNDERTAKER: [illegible] — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 9312
Registered No. 25

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Joel Hamilton Ringer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.
4. COLOR OR RACE: white.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.
6. DATE OF BIRTH: Oct. 22, 1850 (Month) (Day) (Year)
7. AGE: 64 yrs. mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business or establishment in which employed (or employer): X
9. BIRTHPLACE (State or Country): Iowa.
10. NAME OF FATHER: Ruben Ringer.
11. BIRTHPLACE OF FATHER (State or Country): Indiana.
12. MAIDEN NAME OF MOTHER: Martha Freeman
13. BIRTHPLACE OF MOTHER (State or Country): Ohio.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cornelia Ringer
(Address) Payette Idaho.
15.
Filed Nov 14 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 14 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 9 1914, to Nov 14 1914, that I last saw him alive on Nov. 14 1914, and that death occurred on the date stated above, at 11.20 A M.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
Indefinite
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. H. Avery M. D.
Nov 14 1914 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Nov 15 1914
20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

SYMS-YORK CO., PRINTERS & RULERS. BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2050
File No. 9314
Registered No. 498

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Conrad Hiedenbach

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE 82 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Hiedenbach
(Address) .....

15.
Filed 11/10 1914 D D Draeger
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov 30 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1914, to Nov 1 1914, that I last saw h..... alive on 1 1 1914, and that death occurred on the date stated above, at 6 M.
The CAUSE OF DEATH* was as follows:

Lagrippe

..... (Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Cyes
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D D Draeger M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum	Nov 10 1914

20. UNDERTAKER	ADDRESS
E Bobo and Son	Rathdrum Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2051
Primary Registration District No. 2051 12
File No. 9315
Registered No. 434

1. PLACE OF DEATH.
County of Kootenai
City of Twin Lakes (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Hay

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: Oct (Month) 20 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 12 mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Twin Lakes

10. NAME OF FATHER: Glen Hay

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nannie Nancy

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Glen Hay
(Address) Twin Lake

15. Filed 11/10 1914 J D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 10/20 1914, to Oct 20 1914, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature Birth 5 Months

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Brennan M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Home — DATE OF BURIAL: Oct 21 1914

20. UNDERTAKER: Neel — ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

File No. 9317

Registered No. .....

County of Kootenai

City of Clarmore

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard Hildenbrand

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	white	widowed

6. DATE OF BIRTH.

11 (Month) 10 (Day) 1871 (Year)

7. AGE

43 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Machinist

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER Leend Hildebrand

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER D. K.

13. BIRTHPLACE OF MOTHER

(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A. F. Corbin

(Address) Burly wash.

15. Filed Nov. 11 1914 H. L. Mulcahy (Local Registrar)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-10 1914, to 11-11 1914, that I last saw h[illegible] alive on 11-11 1914 and that death occured on the date stated above, at 12-30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Uraemic Poisoning

(Duration) 5 yrs. 6 mos. ? ds.

(Signed) W. S. Bardwell M. D.

11/14 1914 (Address) Othello Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ellensburg Wn — DATE OF BURIAL: .....191.....

20. UNDERTAKER: H. L. Mulcahy — ADDRESS: St Maries, Ida.

WMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 9318
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont
City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Han Haley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Don't no

6. DATE OF BIRTH. H. K. (Month) (Day) 1 (Year)

7. AGE Between 45 & 50 ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) H. K.

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. L. Mulcahy
(Address) St. Anthony

15. Filed Nov. 12 1914 H. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about Oct. 1, 1914
..... (Month) (Day) 191.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found floating in St. Joe River. Body drowned.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Schulte M.D.
Nov 12 1914 (Address) St Anthony, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony Ida | DATE OF BURIAL: Nov 16 1914

20. UNDERTAKER: H. L. Mulcahy | ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9319

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of near Avery

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Wiltfong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 23 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Atherton, Mo

10. NAME OF FATHER: Fred Wiltfong

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Rose Kelly

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charley Baker

(Address) Kansas City

15. Filed Nov 13 191.... W. L. Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 11 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Caught of Cabin Standing on side Hill. Landslide.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. N. Kuhlman J.P. M. D.

11/13 19 4 (Address) Avery, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kansas City Mo — DATE OF BURIAL ..... 191...

20. UNDERTAKER: W. L. Mulcahey — ADDRESS Kansas

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 9321
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Plummer
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Bontilliss

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. November 2nd 1914 (Month) (Day) (Year)

7. AGE: .....Yrs. .....Mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Plummers Ida.

10. NAME OF FATHER: D. L. Bontilliss

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Grace Clupfy

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. L. Bontilliss
(Address) Plummers Ida.

15. Filed Nov. 18 1914 F.P.M'Cormick Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November 16th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191.....
that I last saw h.....alive on .....191.....
and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Acute Pneumonia
(Duration) 4 hours Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F.P.M'Cormick M. D.
11/17 1914 (Address) Plummers Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida. — DATE OF BURIAL: Nov. 17 1914

20. UNDERTAKER: J. L. Jaques — ADDRESS: Plummers Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. .... St.)

File No. 9322
Registered No. .....

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Lebrista

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Macedonian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dont Know (Month) ..... (Day) 1 (Year)

7. AGE about 30 to 35 ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer at Logging camp
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Macedonia

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred G Darkenbach
(Address) Osterick Idaho

15. Filed Nov. 20 1914 W. L. Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sunday 11/15 (Month) ..... (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found Dead
Coroners Jury Verdict Death from Violence
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Fred G Darkenbach & Justice of the Peace M. D.
11/23 1914 (Address) Osterick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Amaiers, Ida — DATE OF BURIAL: 11/23 1914

20. UNDERTAKER: W. L. Mulcahy — ADDRESS: Amaiers

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 9523
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of St. Joe
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Grant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. 11 (Month) 24 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 11 hrs ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Silas Grant

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Mary Harverly

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Silas Grant
(Address) Wapato Wash

15. Filed Nov 24 1914 N. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1914, to Nov. 24 1914, that I last saw h[illegible] alive on [illegible] 1914 and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth
(Duration) ..... Yrs. ..... mos. 11 hrs. ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H M Leete M. D.
11/24 1914 (Address) St Joe Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Maries Ida | DATE OF BURIAL: Nov 25 1914

20. UNDERTAKER: N. L. Mulcahy | ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. .... St.)

File No. 9324
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of near St. Maries

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME T. V. Odgen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 28 (Day) 1905 (Year)

7. AGE: 9 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER H. B. Odgen

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Sena Vandegraft ~~Mary Hedrick~~

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H B. Odgen
(Address) St. Maries

15. Filed Nov. 29 1914 N. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1914, to Nov 28 1914, that I last saw him alive on Nov. 23 1914, and that death occured on the date stated above, at 6.30 P.M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) ..... Yrs. ..... mos. 30 ds.
Contributory (Secondary) Glandular Enlargment of neck
(Duration ..... yrs. ..... mos. 10 ds.
(Signed) Wm. D. Platt M. D.
12/2/5 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries. DATE OF BURIAL: Dec 1 1914

20. UNDERTAKER: N. L. Mulcahy ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 9325
Registered No. .....

1. PLACE OF DEATH,
County of Kootenai
City of St. Maries
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Gordon MacKenzie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: 10th Feb (Month) (Day) 1840 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Victoria N. S.

10. NAME OF FATHER: Robert Kerr

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Harris

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jessie MacDonald
(Address) St Maries

15. Filed Nov 28 1914 H. L. Mulcahy, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 27th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1914, to Nov. 27 1914, that I last saw her alive on Nov 27 1914, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Sudden yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. 10 ds.

(Signed) C. J. Hirschbiel M. D.

11/30 1914 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victoria N.S. Canada — DATE OF BURIAL ..... 191.....

20. UNDERTAKER: H. L. Mulcahy — ADDRESS St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9326
Registered No. .....

Registration District No. 39
Primary Registration District No. 2087

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velma Feller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wife

6. DATE OF BIRTH. March (Month) 26 (Day) 1908 (Year)

7. AGE: 6 yrs. 7 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Athena Ore.

10. NAME OF FATHER J. W. Feller

11. BIRTHPLACE OF FATHER (State or Country) Olympia Wash

12. MAIDEN NAME OF MOTHER Etha Boaler

13. BIRTHPLACE OF MOTHER (State or Country) Montrose Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Feller
(Address) Buhl Ida

15. Filed 11/22 1914 J. A. Murphy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1914, to Nov 20 1914, that I last saw her alive on Nov 20 1914, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Broncho
(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Murphy M. D.
11-21 1914 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 11/22 1914

20. UNDERTAKER: N. B. Evans. — ADDRESS: Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 9326

Name Velma Feeler

Date of Death 11-20-14

Cause of Death Broncho Pneumonia

Contributary Cause of death Flour

(Sign here) J. T. Murphy M.D.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 1009
File No. 932
Registered No. 7

1. PLACE OF DEATH.
County of Canyon
City of New Plymouth (No. ....., ...St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Petrea Johnson
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 18 (Day) 1876 (Year)

7. AGE: 38 yrs. 2 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: J Hanson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Petrea Jacobsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Johnson
(Address) New Plymouth Ida

15. Filed Oct 5 1914 Wm T. Drysdale. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct ~~Sept~~ 8 1914, to Oct 4 1914 that I last saw h~~er~~ alive on Oct 4 1914, and that death occurred on the date stated above, at 8 30P M.

The CAUSE OF DEATH* was as follows:
Puerperal Sepsis

(Duration) 18 yrs. ~~20~~ mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. D.
19 (Address) Wm T Drysdale New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth — DATE OF BURIAL: Oct 5 1914

20. UNDERTAKER: Glenn Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of PARIS,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53
Primary Registration District No. 2092
(No. ..... St.)
File No. 9329
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME, Shelton S. Askew

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
male	white	married (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 9 (Day) 1881 (Year)

7. AGE 32 Yrs. 11 Mos. 30 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... traveling man
(b) General nature of industry, business, or establishment in which employed (or employer)..... for banking firm

9. BIRTHPLACE (State or Country) Oklahoma

10. NAME OF FATHER B. B. Askew

11. BIRTHPLACE OF FATHER (State or Country) Alabama

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 12/1/ 1914 P. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1914, to Nov. 8 1914, that I last saw h. in alive on Nov. 8 1914 and that death occured on the date stated above, at 4 45 8. M.

The CAUSE OF DEATH* was as follows:
pneumonia (left lobar)

(Duration) Yrs. 1 mos. 21 ds.
Contributory (Secondary) tuberculosis
(Duration 15 yrs. — mos. — ds.
(Signed) L. A. Hottendorf M. D.
Nov 8 1914 (Address) PARIS, IDAHO.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. — yrs. 1 mos. 21 days. In the State. — yrs. 3 mos. — days
Where was disease contracted if not at place of death? unknown
Former or usual residence Marietta Okla.

19. PLACE OF BURIAL OR REMOVAL: Marietta Okla — DATE OF BURIAL: 191

20. UNDERTAKER: Vincent — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PYRS. & BOBS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Aberdeen

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116

Primary Registration District No. 2195

(No. ....., ... St.)

File No. 7 9330

Registered No. 24

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeanetta Weins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Widowed

6. DATE OF BIRTH: April (Month) 18 (Day) 1846 (Year)

7. AGE: 68 yrs. 6 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Lantzen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. J. Weins
(Address) Aberdeen Ida

15.
Filed NOV 4 1914 McMontinney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 8 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Myocarditis -
No physician in attendance -

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) McMontinney M. D.
Nov 9 1914 (Address) Aberdeen

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fremont Cemetery	Nov 10 1914

20. UNDERTAKER	ADDRESS
D Jones Atty	Aberdeen Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of Genesee (No. ..... St.)

Registration District No. 6
Primary Registration District No. 2142
File No. 9331
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lenora Josephine Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH: Oct. (Month) 14 (Day) 1914 (Year)

7. AGE: ... yrs. ... mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: /
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Einar Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Severine Svingstad

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Einar Johnson
(Address) Genesee Idaho

15. Filed Nov. 4 1914 W. N. Eblen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 3 (Day) 191X (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...
and that death occurred on the date stated above, at 9a.m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. ... mos. 6 hrs.

Contributory (Secondary) /
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. H. Eblen Regular M. D.
Nov. 3 1914 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Norwegian Cem. DATE OF BURIAL: Nov. 5 1914

20. UNDERTAKER: Fallon ADDRESS: Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65.
Primary Registration District No. 2145.
File No. 9332
Registered No. .....

1. PLACE OF DEATH.
County of Latah.
City of Potlatch.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold Johnny Nyhus.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.

4. COLOR OR RACE: white.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single.

6. DATE OF BIRTH. Jan. (Month) 25 (Day) 1914 (Year)

7. AGE: Yrs. 9 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): ✓

9. BIRTHPLACE
(State or Country) Idaho.

10. NAME OF FATHER: Kyllo Richard Nyhus.

11. BIRTHPLACE OF FATHER
(State or Country) Norway.

12. MAIDEN NAME OF MOTHER: Mary Krogh.

13. BIRTHPLACE OF MOTHER
(State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Richard Nyhus
(Address) Potlatch Idaho

15.
Filed Nov. 21st 1914. Dr. J.W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 21. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1914, to Nov 21 1914, that I last saw him alive on Nov. 20 1914, and that death occured on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:
Spasmodic Laryngitis

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Rickets.
(Duration) yrs. mos. ds.

(Signed) J.W. Thompson M. D.
Nov 21 1914 (Address) Potlatch.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: Nov 22nd 1914

20. UNDERTAKER: Parents — ADDRESS: Potlatch.

BYMS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 0333
Registered No. .....

1. PLACE OF DEATH.
County of Latah.
City of Potlatch.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vida Opal White.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. July (Month) 1st (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds. 16
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... ✓
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Alfred James White.

11. BIRTHPLACE OF FATHER (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Blanche Hubbard.

13. BIRTHPLACE OF MOTHER (State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alfred James White
(Address) Potlatch Idaho

15. Filed Nov. 15th 1914
D. W. Thompson
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1914, to Nov 15 1914, that I last saw her alive on Nov 15 1914, and that death occured on the date stated above, at 8 30A M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia.

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) ✓

(Duration ..... yrs ..... mos. ..... ds.

(Signed) J. W. Thompson M. D.
1914 (Address) Potlatch Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: Nov. 16. 1914

20. UNDERTAKER: Parents — ADDRESS: Potlatch

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 9311
Registered No. 72

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME melvin Gutches
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
m	W	married

6. DATE OF BIRTH
Jan 29 1856
(Month) (Day) (Year)

7. AGE
57 yrs. 9 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) mich

10. NAME OF FATHER Chancil Gutches

11. BIRTHPLACE OF FATHER
(State or Country) Maryland

12. MAIDEN NAME OF MOTHER martha Covalt

13. BIRTHPLACE OF MOTHER
(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leland Gutches
(Address) Moscow Idaho

15. Filed Nov 25 1914 J T Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nove 24 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11 1914, to Nov. 24 1914, that I last saw him alive on Nov. 23 1914 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) ..... yrs. 3 mos. ..... ds.
Contributory Age
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Asphra M. D.
Nov 25 1914 (Address) Moscow Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: viola Idaho — DATE OF BURIAL: Nove 27 1914

20. UNDERTAKER: Geo Stetz — ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 9336
Registered No. 76

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME S. F. Spencer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 11 (Day) 1856 (Year)

7. AGE: 58 yrs. 7 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: S. F. Spencer Sr

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Maga Eckard

13. BIRTHPLACE OF MOTHER (State or Country): Norwegn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. G. Spencer
(Address) Moscow

15. Filed Nov 22 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1914, to Nov 18 1914, that I last saw him alive on Nov. 18, 1914, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Sepsis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Diabetes

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gilman M. D.

11-21 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Nov 24 1914

20. UNDERTAKER: [illegible] | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Viola
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
(No. ..... , ... St.)

File No. 9336
Registered No. 77
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Missouri Ann Gunter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 26 (Day) 1842 (Year)

7. AGE: 72 yrs. — mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Seneca Webb

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orpha Garvin
(Address) Viola Ida

15. Filed Dec 1 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 30th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1907, to Nov 30 1914, that I last saw her alive on Nov 30 1914 and that death occurred on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:
Old age and heart failure

(Duration) 7 yrs. mos. ds.
Contributory (Secondary) Epileptic
(Duration) 13 yrs. mos. ds.

(Signed) Orpha Garvin Murdock
Dec 1 1914 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Viola Cemetery
DATE OF BURIAL: Dec 2 1914

20. UNDERTAKER: No Undertaker
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 18760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. [redacted] 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 9335
Registered No. 28

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest Olney Byers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
March 28 1910
(Month) (Day) (Year)

7. AGE
4 yrs. 5 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Latah Co. Idaho

10. NAME OF FATHER Ephraim Byers

11. BIRTHPLACE OF FATHER (State or Country) Kentuck Co Iowa

12. MAIDEN NAME OF MOTHER Joanna Carter

13. BIRTHPLACE OF MOTHER (State or Country) Kentuck Co Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ephraim Byers
(Address) N. Jefferson Street

15.
Filed Apr 20 1914 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Apr 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19, 1914., to Same only once, 191., that I last saw him alive on April 16 1914, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Measles

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Sudden retrocession
(Duration) About 3 hours yrs. ..... mos. ..... ds.
(Signed) F. W. Leitch M. D.
4/20 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bud Church — DATE OF BURIAL: Apr 21 191 4

20. UNDERTAKER: None — ADDRESS:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011

File No. 1 9358
Registered No. 15
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gillis J McBain

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: not known (Month) 1829 (Year) (Day)

7. AGE: 85 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry business, or dstablishment in which employed (or employer): pensioner

9. BIRTHPLACE (State or Country): Kokomo Ind

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo H Stitz
(Address) Moscow

15. Filed Nov 22 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 20th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17th 1914, to Nov 20th 1914, that I last saw him alive on Nov 20th 1914, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Brights disease and heart trouble

(Duration) don't Know yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Adair M. D.
Nov 21 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Nov 22 1914

20. UNDERTAKER: [illegible] Stitz — ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 9339
Registered No. 74

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward H. Krier

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 23 (Day) 1849 (Year)

7. AGE: 65 yrs. 7 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mason
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Thomas Krier

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Margaret J. McDowell

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed. Krier
(Address) Bovill, Idaho.

15. Filed Nov 21 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1914, to Nov 19 1914, that I last saw him alive on Nov. 19 1914, and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:
Do not know - He died very suddenly and suppose it was an affection of the right side.
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.
Nov 21 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Nov 21 1914

20. UNDERTAKER: Geo Metz — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 9310
Registered No. 73
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Swadener

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 3 (Day) 1850 (Year)

7. AGE: 64 yrs. 5 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor & Builder
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Libertytown, Maryland

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert B. Swadener
(Address) Orofino, Idaho.

15. Filed Nov 18 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 26 1914, to Nov. 16, 1914, that I last saw h[illegible] alive on Nov. 16 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebro Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Gilman M. D.

11/18 1914 (Address) E. Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Nov 19 1914

20. UNDERTAKER: See Stats — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 1931
Registered No. 71

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James W. Dorsey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH: Jan 31 1837 (Month) (Day) (Year)

7. AGE: 77 yrs. 9 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virgind

10. NAME OF FATHER: James W. Dorsey

11. BIRTHPLACE OF FATHER (State or Country): Virgina

12. MAIDEN NAME OF MOTHER: Ol—

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Dorsey
(Address) Farmington, Wash.

15. Filed Nov 26 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 26" (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14 1914, to Nov. 26" 1914, that I last saw him alive on Nov. 25 1914, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Shock following Prostatectomy

(Duration) ——yrs. ——mos. 2 ds.

Contributory (Secondary) Hypostatic Pneumonia of Prostate.

(Duration) ——yrs. ——mos. ——ds.

(Signed) H. H. Carithers M. D.

Nov 26" 1914 (Address) Moscow Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ——yrs. ——mos. 11 days. In the State ——yrs. ——mos. 11 days.

Where was disease contracted if not at place of death? W. Va.

Former or usual residence Garfield, Washington

19. PLACE OF BURIAL OR REMOVAL: Garfield Wn — DATE OF BURIAL: Nove 27 1914

20. UNDERTAKER: Geo Stetz. — ADDRESS: Moscow.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 9342

Registered No. 70

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 61

Primary Registration District No. ~~274~~ 1011

County of Latah

City of Moscow (No. 904, South St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hanna Williams

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1845 (Year)

7. AGE: 68 yrs. 11 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cut Home.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dayton Indiana.

10. NAME OF FATHER: James S Paige

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Hannah Rarick

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John C Williams
(Address) Jerome Idaho

15. Filed Nov 25 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 29 — 1914, to Nov. 25 — 1914 that I last saw h-r alive on Nov. 24 1914 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Wilk M. D.

Nov. 25 1914 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Nov 26 1914

20. UNDERTAKER: Geo. Seltz — ADDRESS: Moscow

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jerome Vollmer
City of Vollmer

Registration District No. 50
Primary Registration District No. 2129
(No. ....., ... St.)

File No. 931
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 3 (Day) 1914 (Year)

7. AGE ....Yrs....Mos. 9 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho, Vollmer

10. NAME OF FATHER: Henry weber

11. BIRTHPLACE OF FATHER (State or Country): Box Co Ill

12. MAIDEN NAME OF MOTHER: Millie Crow

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry weber
(Address) Vollmer, Idaho

15. Filed 10-12 1914 H.C. Parrish Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-11 1914, to 10-12 1914, that I last saw him alive on 10-11 1914, and that death occured on the date stated above, at 6-a M.

The CAUSE OF DEATH* was as follows:
Prematurity
6 months utero
(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary) Asphyxia
(Duration ....yrs. ....mos. 4 ds.
(Signed) H. C. Parrish M. D.
10-12 1914 (Address) Flo, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fletcher cemetary
DATE OF BURIAL: 10-12 1914

20. UNDERTAKER: Henry weber
ADDRESS: Vollmer Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of .....

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

File No. 9344

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Llewellyn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. November 11 (Month) (Day) 1914 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 0 hrs. or 10 min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bannock

10. NAME OF FATHER: James Llewellyn

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Rosamond Cora Sexton

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Llewellyn per C.S.

(Address) Preston, Idaho

15. Filed Nov 25 1914 Dallas Rulle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 11 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 11, 1914, to November 11 1914, that I last saw h i m alive on November 11, 1914, and that death occured on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:

Miscarriage at 5 mos.

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Bland M. D.

11/11 1914 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Camp 3

DATE OF BURIAL: 11—11—1914

20. UNDERTAKER: 0

ADDRESS: 0

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 2119

File No. 935

City of Preston (No. ....., ... St.)

Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Christena Erickson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug (Month) 17 (Day) 1838 (Year)

7. AGE: 76 yrs. 4 mos. 3 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Jacobsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ole Erickson

(Address) Mink Creek Idaho

15.

Filed Nov 25 1914 Allen R Culley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Aug 11 1914, to Nov. 19 1914, that I last saw her alive on Aug. - 1914 and that death occurred on the date stated above, at 12 45 P. M.

The CAUSE OF DEATH* was as follows:

Exanstion Sullowing a paralytic Stroke

about
(Duration) ..... yrs. 4 mos. - ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen R Culley M. D.

19 ..... (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mink Creek — DATE OF BURIAL: Nov. 20 1914

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Mink Creek
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 9346
Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans Larsen Neilsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
July (Month) 25 (Day) 1835 (Year)

7. AGE
79 yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Lars Neilsen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Niels P. P. Rehalt
(Address) Minkcreek

15.
Filed NOV. 25 1914 Dallas Rudd
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no doctor in attendance 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:
Stated by relatives - A Paralytic Stroke

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dallas Rudd M. D.
19... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mink Creek	Nov. 25 1914

20. UNDERTAKER	ADDRESS
W. A. Skidmore	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 1 9548
Registered No. 56

1. PLACE OF DEATH.
City County of Preston
City of Franklin Co (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Walter Jenkins
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 19 (Day) 1881 (Year)

7. AGE: 33 yrs. 11 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Jordan Utah

10. NAME OF FATHER: Thomas Jenkins

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Minerva Beckstead

13. BIRTHPLACE OF MOTHER (State or Country): South Jorda Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W E Steers
(Address)

15. Filed Nov. 9 1914 Dr Allen E Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4 1914 to Nov. 5 1914 that I last saw h[illegible] alive on Nov. 4 1914, and that death occurred on the date stated above, at 12 5/6 M.

The CAUSE OF DEATH* was as follows:
Disease supposed to be Typhoid Fever
(Duration) ..... yrs. about 2 hours mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. 4 mos. ..... ds.
(Signed) A E Cutler M. D.
19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview Idaho — DATE OF BURIAL: Nov. 7 1914

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 36
County of Twin Falls Primary Registration District No.
City of Rock Creek (No. ....., ... St.)
File No. 2034
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Brackenberry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: November (Month) 18 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 2½ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rock Creek Twin Falls Co., Idaho

10. NAME OF FATHER: See. Henry Brackenberry

11. BIRTHPLACE OF FATHER (State or Country): Alma, Idaho

12. MAIDEN NAME OF MOTHER: Margaret Walters

13. BIRTHPLACE OF MOTHER (State or Country): Twin Falls Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Lee Brackenberry
(Address) Rock Creek Idaho

15. Filed Jan 19 1915 J R Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1914, to Nov 18 1914
that I last saw h[illegible] alive on Nov 18 1914
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
7½ months gestation
assigned as ascertainable
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Cause unknown
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Davis M. D.
Nov 19 1914 (Address) Kimberly Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rock Creek Idaho DATE OF BURIAL: Nov 19 1914

20. UNDERTAKER: None ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Rock Creek

Registration District No. 36
Primary Registration District No.
(No. , St.)

File No. 9334
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Brackenberry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 18 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 hours mos. ..... ds.
IF LESS than 1 day how many 2 hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Twin Falls Co, Idaho

10. NAME OF FATHER: George Henry Brackenberry

11. BIRTHPLACE OF FATHER (State or Country): Edwardsville Idaho

12. MAIDEN NAME OF MOTHER: Margarite Walters

13. BIRTHPLACE OF MOTHER (State or Country): Elizabeth Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Geo. Brackenberry
(Address) Rock Creek Idaho

15.
Filed Nov 19 1914 M Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1914, to Nov 18 1914 that I last saw him alive on Nov 18 1914 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
7½ months gestation
Cause unknown
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. M. Davis M. D.
Nov 19 1914 (Address) Kimberly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rock Creek Idaho — DATE OF BURIAL: Nov 19 1914

20. UNDERTAKER: none — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. ____
(No. ____, ____ St.)

File No. 9350
Registered No. 117

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel G Boyer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. Mar (Month) 16 (Day) 1893 (Year)

7. AGE: 21 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Woolery

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. D. Boyer
(Address) Idaho Falls Ida.

15.
Filed Nov 21 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-15 1914, to 11-20 1914, that I last saw h[illegible] alive on 20th Nov. 1914, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
peritonitis
of short (Duration) ✓ Yrs. ✓ mos. ✓ ds.
Contributory (Secondary) Salpingitis
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) J. H. Coulthard M. D.
11/21 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cem — DATE OF BURIAL: Nov 22 1914

20. UNDERTAKER: J H Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-0
(No. .... St.)

File No. L 935
Registered No. 116

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth McIlvaine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WID. OWED OR DIVORCED~~: Single (Write the word.)

6. DATE OF BIRTH. June (Month) 5 (Day) 1893 ~~1914~~ (Year)

7. AGE: 21 Yrs. 5 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Mc Ilvaine

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jessie Brown
(Address) Dillon Mont

15. Filed Nov 17 1914 E Hummel Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1914, to Nov 11 1914, that I last saw her alive on Nov 11 1914 and that death occured on the date stated above, at 10-30 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

one week (Duration) Yrs. — mos. — ds.

Contributory (Secondary) Salpingitis

(Duration) yrs. mos. ds.

(Signed) J. H. Coulthard M. D.

11/17/14 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: Nov 19[illegible]

20. UNDERTAKER: G H Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2150

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. .....

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Leroy Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. Nov (Month) 6 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER Chester Brown

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Florence Evans

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chester Brown

(Address) Idaho Falls Ida

15. Filed Nov 10 1914 J. E. Bennett Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 4-30A M.

The CAUSE OF DEATH* was as follows:

Compression fracture
on Cor & burning birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H D Spencer M. D.

Nov 9 1914 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. ~~PLACE OF~~ BURIAL ~~OR REMOVAL~~ Rose Hill Cem — DATE OF BURIAL 11-10 1914

20. UNDERTAKER J. H. Hunt — ADDRESS Idaho Falls

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9353

Registered No. 114

Registration District No. 72

Primary Registration District No. 21[illegible]

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Shedrick Ray Empey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 20 (Day) 1893 (Year)

7. AGE: 20 Yrs. 10 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ammon, Ida

10. NAME OF FATHER: Eph. Empey

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah A. Rhodes

13. BIRTHPLACE OF MOTHER (State or Country): Lehi. Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. S. Empey

(Address) R D 3 Idaho Falls

15.

Filed Nov 7 1914

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1914, to Nov. 6 1914, that I last saw h[illegible] alive on Nov 5 1914 and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Endocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Typhoid Fever

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) A. R. Bodingmark M. D.

11/7 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ammon Ida

DATE OF BURIAL: 11 8 1914

20. UNDERTAKER: C C Linwood

ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-6
(No. ....., ... St.)

File No. 9354
Registered No. 113

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Mary Payne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 28th. (Day) 1840 (Year)

7. AGE: 73 Yrs. II Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Louis Wysong

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Eleanior Wright

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. D. Payne
(Address) Idaho Falls, Idaho

15.
Filed Nov 7 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1914, to November 1914, that I last saw h[er] alive on Nov 3 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Disease of the Gall Bladder

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Miller M. D.
11/3 1914 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetary
DATE OF BURIAL: Nov 5th 1914

20. UNDERTAKER: Thos. W. Muhleman,
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STAR - YORK CO., PRTG. & STNR. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9357
Registered No. 110

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)
Registration District No. 73
Primary Registration District No. 2150

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ray Willis Zenke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 28 (Day) 1914 (Year)

7. AGE: ....Yrs. 10 Mos. ....ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alberta Canada

10. NAME OF FATHER: C. J. Zenke

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Maud Leavitt

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): C. J. Zenke
(Address): Cardston Alberta Canada

15. Filed Nov 23 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23d (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occured on the date stated above, at — M.
The CAUSE OF DEATH* was as follows:
No Medical Attendance
Catarrhal Stomach

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) T. O. Farley Coroner M. D.
11/25 1914 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: Nov 25 1914

20. UNDERTAKER: Thos. W. Muchleman — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Gannett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)
File No. 958
Registered No. 23
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Hough

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed
6. DATE OF BIRTH: April (Month) 11 (Day) 1828 (Year)
7. AGE: 86 yrs. 7 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Keeping House
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Pennsylvania
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Hough
(Address) Gannett Idaho
15.
Filed Nov 25 1914 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 21 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1914 to ~ 191, that I last saw h er alive on Nov 20 1914 and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Robert H. Wright M. D.
Nov 27 1914 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Crawfordsville Iowa
DATE OF ~~BURIAL~~: Nov 24 1914
20. UNDERTAKER: R W Harris
ADDRESS: Hailey Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 9359
Registered No. 24

1. PLACE OF DEATH.
County of Blaine
City of Bellevue
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James McGlochlin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 1 (Day) 1836 (Year)

7. AGE: 78 yrs. 3 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B McGlochlin
(Address) Tekoa Ida

15. Filed Nov 10 1914 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1914, to Nov 6 1914, that I last saw him alive on Nov 6 1914 and that death occurred on the date stated above, at 7 45 A M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of the heart
(Duration) ..... yrs. 1 mos. ..... ds.
Contributory Pneumonia (Secondary) Nov 1914
(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) O. J. Allen M. D.
11/8 1914 (Address) Bellevue

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue | DATE OF BURIAL: Nov 7 1914

20. UNDERTAKER: R D Harris | ADDRESS: Hailey

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2077

City of Hailey

(No. ....., ... St.)

File No. [illegible]

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte Apollonia Cramer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept. 17 1844
(Month) (Day) (Year)

7. AGE: 70 yrs. 2 mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Savoy.

10. NAME OF FATHER: Gottlieb Bauer

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ottilie Cramer
(Address) Hailey, Idaho.

15.
Filed Nov 25 1914 Robert H Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
11. 23 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Nov 23 1914, that I last saw her alive on Nov. 23 1914, and that death occurred on the date stated above, at 9 PM.

The CAUSE OF DEATH* was as follows:
Valvular Disease of Heart

(Duration) ..... yrs. 2 mos. — ds.

Contributory (Secondary) Age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Plummer M. D.

11. 23 1914 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida — DATE OF BURIAL: Nov 25 1914

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9361

Registered No. 26

1. PLACE OF DEATH.

County of Beaune

City of Hailey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. 2072

(No. ..... St.)

2. FULL NAME John D. Sears

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Wht	Single

6. DATE OF BIRTH

..... (Month) 1 (Day) ..... (Year)

7. AGE

Years 73 mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. D. Nickerson

(Address) Hailey

15.

Filed ..... 191 ..... Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.

19.... (Address) County Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Atchison Kas	✓ 191 ✓

20. UNDERTAKER	ADDRESS
R. D. Harris	Hailey Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

File No. 9363

Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert F. Clemons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November 21st 1840 (Month) (Day) (Year)

7. AGE: 73 Yrs. 11 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Granby, Conn.

10. NAME OF FATHER: Willis Clemons

11. BIRTHPLACE OF FATHER (State or Country): Connecticut

12. MAIDEN NAME OF MOTHER: Almira Gaines

13. BIRTHPLACE OF MOTHER (State or Country): Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. L. Clemons

(Address) Salt Lake City Utah

15.

Filed Nov. 16th 1914

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ~~1914~~ to ~~1914~~;

that I last saw him alive on ~~1914~~;

and that death occured on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Natural Causes
(Dropped dead while at work)

(Duration) ~~Yrs.~~ ~~mos.~~ ds.

Contributory (Secondary) .....

(Duration ~~yrs.~~ ~~mos.~~ ds.

(Signed) F. K. Johnson M.D.

11/16/1914 (Address) Nampa, Idaho Coroner

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Carleton Neb. DATE OF BURIAL: 11/16 1914

20. UNDERTAKER: W. C. Dyer ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of Caldwell Rural.

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 9314
Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margret Demmerline

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.: March (Month) 27 (Day) 1839 (Year)

7. AGE: 75 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: John H. Decker.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Dorothea Lenow

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) ✓ John Hoffnick
(Address) Caldwell, Idaho.

15. Filed Nov. 23 1914 — John S. Meyers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from 191~~, ~~to~~ Nov 21 1914, ~~that I last saw h. alive on 191~~, and that death occured on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy. Death was sudden

..... (Duration) ..... Yrs. ..... mos. ½ hour

Contributory (Secondary): None

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Meier M. D.

11/23 1914 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Nov 23 1914

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 934

Registered No. 68

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of (Limits) Rural (Melba Rural.) (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Naftzger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 2 (Day) 1843 (Year)

7. AGE: 71 Yrs. — Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: ✓ ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓ ✓

12. MAIDEN NAME OF MOTHER: ✓ ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ellen Naftzger
(Address) Green Leaf Idaho

15. Filed 11-29-1914 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from (6 p.m.) Nov. 28 1914, to (8 a.m.) Nov. 28 1914, that I last saw h— alive on (6.30 p.m.) Nov. 28 1914, and that death occured on the date stated above, at 7. a. M.

The CAUSE OF DEATH* was as follows:

Heart failure.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): acute gastritis.

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) John S. Meyer M. D.

11/28/1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roswell. Idaho. DATE OF BURIAL: 11/29/1914

20. UNDERTAKER: W. C. Dyer. ADDRESS: Caldwell. Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 9361
Registered No. 69

1. PLACE OF DEATH.
County of Canyon
City of Roswell (No. St.)
If death occurs away from usual residence, give facts called for under special information. Parma & Caldwell all.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena Johnston.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July 25 1877 (Month) (Day) (Year)

7. AGE: 37 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holland

10. NAME OF FATHER: Jno Wrenth.

11. BIRTHPLACE OF FATHER (State or Country): Holland,

12. MAIDEN NAME OF MOTHER: Dont Know,

13. BIRTHPLACE OF MOTHER (State or Country): Holland,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Guy Johnston.
(Address) Parma R. 3. Idaho

15. Filed Dec. 4 1914
John L. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1914, to Dec 4 1914, that I last saw her alive on Dec 4 1914, and that death occured on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) R J Clum M. D.
12/4 1914 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Parma Roswell Idaho
DATE OF BURIAL: 12/4 1914

20. UNDERTAKER: W. E. Dyer
ADDRESS: Caldwell.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 46
Registered No. 9367

1. PLACE OF DEATH
County of Washington
City of Weiser (No. ..... St.)
Registration District No. 86
Primary Registration District No. 1010
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Henry Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH
Oct 23 1[illegible]
(Month) (Day) (Year)

7. AGE
82 yrs. — mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Henry Johnson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. D. E. Lambert
(Address) Halleck Nevada

15.
Filed Oct. 25th 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
October 25 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct – 6 1914, to Oct – 24 1914 that I last saw him alive on Oct 24 – 1914 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Intestinal Stasis – Traumatic Ileus

..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory Fall
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S B Dudley M. D.
..... 19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Weiser Ida — DATE OF BURIAL Oct 26 1914

20. UNDERTAKER L. C. Northam — ADDRESS Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 212
City of Weiser (No. ..... St.)
File No. 9368
Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Edwards

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE About 45 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wales, England

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Information [illegible]
(Informant) .....
(Address) .....

15. Filed Nov 2nd 1914 W. R. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH ..... 191.... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191...., to ..... 191.... that I last saw h..... alive on ..... 191.... and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Struck By a Locomotive at Olds Ferry, Ida — Nov 1 — 1914 — Accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James J. McCann ~~M. D.~~
Nov 2 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida
DATE OF BURIAL: Nov 5 1914

20. UNDERTAKER: L. C. [illegible]
ADDRESS: Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9363
Registered No. 47

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 212
City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. D. Williams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH — — 1
(Month) (Day) (Year)

7. AGE — — —
yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Traveling Salesman
(b) General nature of industry business or establishment in which employed (or employer) Shapleigh Hardware Co. St Louis Mo.

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. L. Northam
(Address) Weiser Ida

15.
Filed 11/5/ 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 4 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...
that I last saw h..... alive on ....., 191...
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Crushed Beneath Automobile
While driving around Curve
Car Turned over — accidental
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. Coroner ds.
(Signed) James T. McCamant M. D.
Nov 4/ 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Temple Texas
DATE OF BURIAL ..... 191...

20. UNDERTAKER L. L. Northam
ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010.

(No. ....., ... St.)

File No. 938

Registered No. 48.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Belle Stowe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. 2 (Month) 7 (Day) 1887 (Year)

7. AGE: 27 Yrs. 9 Mos. 28 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Telephone Operator
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER David Stowe.

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Lizzie Greenwyer

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James H Stowe
(Address) Payette Ida

15. Filed 11/21/1914 W R Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 6th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5th 1914, to Nov 6th 1914, that I last saw h[illegible] alive on Nov 6th 1914, and that death occured on the date stated above, at 6.15 P.M.

The CAUSE OF DEATH* was as follows: Shock following Abdominal Pain

.....(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Intestinal Paralysis

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W R Hamilton M. D.

19..... (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ontario Ore. | DATE OF BURIAL .....191.....

20. UNDERTAKER L C Mosher | ADDRESS Weiser

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 971
Registered No. 49

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 56
County of Washington
City of Weiser (No. ..... St.) Primary Registration District No. 1010

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Edward Hubbard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 28 (Day) 1903 (Year)

7. AGE: 11 yrs. 2 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Torrington Wyo.

10. NAME OF FATHER: H. J. Hubbard

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary J. Pooks.

13. BIRTHPLACE OF MOTHER (State or Country): Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. J. Hubbard
(Address) New Meadows

15. Filed 11/11/ 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6 1914, to Nov. 10 1914, that I last saw him alive on Nov. 10 — 1914, and that death occurred on the date stated above, at 3:20 A.M.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis.

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Coleman M. D.
19 ..... (Address) New Meadows.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Meadows Ida. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: L. L. Northam ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

86

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9372
Registered No. 83

1. PLACE OF DEATH. ✓
County of Washington
City of Weiser

Registration District No.
Primary Registration District No. 2412
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Josephine Barber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH December – 9 – 1913
(Month) (Day) (Year)

7. AGE yrs. 11 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Weiser Idaho

10. NAME OF FATHER Joe C. Barber

11. BIRTHPLACE OF FATHER (State or Country) State of Missouri

12. MAIDEN NAME OF MOTHER Bessie McConnell

13. BIRTHPLACE OF MOTHER (State or Country) State of Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe C Barber
(Address) Weiser Idaho

15.
Filed 11/20/ 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH November – 19 – 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 – 1914, to Nov 19 – 1914
that I last saw her alive on Nov 19 1914
and that death occurred on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:
Asthenia following shock in Case of Prolonged and difficult Lactation
(Duration) yrs. mos. 10 ds.

Contributory (Secondary) .....
(Duration) yrs. mos. ds.

(Signed) S. B. Dudley M. D.
Nov 19 1914 (Address) Weiser, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Weiser Idaho
DATE OF BURIAL 11/20 1914

20. UNDERTAKER R. F. Bowen
ADDRESS Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 93[illegible]
Registered No. 5-1

1. PLACE OF DEATH
County of Washington
City of Weiser (No. 3 miles east of Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Coffman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 7 (Day) 1867 (Year)

7. AGE: 47 yrs. 8 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of Ohio Perry County

10. NAME OF FATHER: J. W. Coffman

11. BIRTHPLACE OF FATHER (State or Country): Licking Co. State of Ohio

12. MAIDEN NAME OF MOTHER: Eunice A. Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Licking Co. State of Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Coffman
(Address) Weiser; Idaho

15.
Filed 11/24/1914
W. R. Brumbach
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1914, to November 23 1914
that I last saw him alive on November 22 1914
and that death occurred on the date stated above, at 8:20 a. M.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(Duration) 4 yrs. — mos. — ds.
Contributory (Secondary): none
(Duration) yrs. mos. ds.

(Signed) James A Young M. D.
Nov 23 1914. (Address) Weiser, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho
DATE OF BURIAL: Nov. 25 1914

20. UNDERTAKER: R. W. Bowen
ADDRESS: Weiser; Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9374
Registered No. 52

1. PLACE OF DEATH.
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 1010
(No. ....., ... St.)

2. FULL NAME Mary F. Thurman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 42 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) [illegible]

10. NAME OF FATHER [illegible]

11. BIRTHPLACE OF FATHER (State or Country) [illegible]

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (State or Country) [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C.C. Mills
(Address) Weiser Ida

15.
Filed 11/25/ 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 24 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914, to Nov 24 1914 that I last saw h-r alive on Nov 23 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Incurable Insanity

..... (Duration) ..... yrs. 6 mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.
11/25/ 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho
DATE OF BURIAL: [illegible] 1914

20. UNDERTAKER: [illegible]
ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 88
County of Washington Primary Registration District No. 2112
City of Weiser (No. 2 miles east of city St.)
File No. 9345
Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe E. Martson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January (Month) 8 (Day) 1881 (Year)

7. AGE: 33 yrs. 10 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of Illinois

10. NAME OF FATHER: A. D. Martson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Marie Burke

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christian Martson
(Address) Weiser Idaho

15.
Filed Nov 28th 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1914, to Nov 27th 1914
that I last saw him alive on Nov 24th 1914
and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. R. Hamilton M. D.
11/27/ 1914 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho
DATE OF BURIAL: Dec. 1 1914

20. UNDERTAKER: R. W. Bowen
ADDRESS: Weiser, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF ~~DEATH~~
County of Latah
City of Collins
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66
Primary Registration District No. 2146
File No. 7 03
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pat May

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mch (Month) 17 (Day) 1870 (Year)

7. AGE: 44 yrs. 7 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): Logging

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dave Gentry
(Address) Bovill Ida

15. Filed Nov 13 1914 J L Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Strangulation
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Alcoholic Excess
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L B McCarter Coroner M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Calura Mo.
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Jos Pickard
ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 6-10 R. 1-15-17

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No. 2-1-4
(No. ....., ... St.)

File No. 893

Registered No. .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurred outside usual residence, give name called for such special information.

2. FULL NAME John P Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. (Month) (Day) (Year): 1885
7. AGE: 29 yrs. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Lather
(b) General nature of industry, business or establishment in which employed (or employer): C. H. Evans
9. BIRTHPLACE (State or Country): Ill.
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (State or Country): not known
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (State or Country): not known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....
Filed Nov 18 1917 J L Shawhan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) — 17 (Day) — 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/17 1917 to 11/17 1917 that I last saw him alive on Nov 17 1917 and that death occured on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Crushing injury to Skull

(Duration) ..... Yrs. ..... mos. ..... da.
Contributory (Secondary) Accidental
(Duration ..... yrs. ..... mos. ..... da.
(Signed) F C Gibson M.D.
11/18/1917 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paloure Wash — DATE OF BURIAL: Nov 18 1917

20. UNDERTAKER: E Anderson — ADDRESS: Paloure

YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2010
Primary Registration District No. 1010
(No. ....., ... St.)

File No. 934
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Michael Yergenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 2 (Day) 1853 (Year)

7. AGE: 57 yrs. — mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Peter Yergenson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) Emmett Idaho

15.
Filed 11-28 1914 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1914, to Nov 22 1914 that I last saw h[illegible] alive on Nov 21 1914, and that death occurred on the date stated above, at 12-15 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia (acute)

..... (Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J L Reynolds M. D.
11-28 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery — DATE OF BURIAL: Nov 24 1914

20. UNDERTAKER: C D Bucknum — ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form P. H. No. 5. (Rev. Feb. 11.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2 1 2

County of Canyon — Primary Registration District No. — File No. 9379

City of Emmett (No. ——, ——St.) — Registered No. ——

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abraham L. Gilmore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH — Nov (Month) 12 (Day) 1853 (Year)

7. AGE — [redacted] yrs. — mos. 12 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION (a) Trade, profession, or particular work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER David W. Gilmore

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Higginbotham

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David W. Gilmore
(Address) Emmett Idaho

15. Filed Nov 26 1914 — [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Nov. (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1914, to Death same day that I last saw h— alive on Nov 23 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Rupture of Sub Clavian Artery and Left Side

(Duration) —— yrs. 9 mos. few hours ds.

Contributory (Secondary) Aneurism

(Duration) —— yrs. —— mos. —— ds.

(Signed) J. A. Reynolds M. D.

11-23 1914 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — Emmett Cemetery — DATE OF BURIAL — Nov 26 1914

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. A PERMANENT RECORD.

Every item of information should be carefully supplied, and should be stated EXACTLY. If unknown, the fact should be stated. Exact dates should be given wherever possible. Dates may be properly classified. Exact dates should be given wherever possible. Dates may be properly classified.

CAUSE OF DEATH in plain terms. Indefinite or unsatisfactory terms should not be used. Exact statement of CAUSE OF DEATH in plain terms. Indefinite or unsatisfactory terms should not be used. Exact statement of OCCUPATION is very important. See instructions on back of certificate. OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of Pearl
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2010
Primary Registration District No.
(No. , St.)

File No. 9381
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Luella May Van Horten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: Sept (Month) 18 (Day) 1861 (Year)

7. AGE: 53 yrs. 2 mos. 12 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Allen T. Drake

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Ann Eliza Wilkinson

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. Van Horten
(Address) Pearl Idaho

15.
Filed 11-28-1914
J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1914, to death 1914
that I last saw her alive on Sept 19th 1914
and that death occurred on the date stated above, at a m.
The CAUSE OF DEATH* was as follows:
Carcinoma of breast

(Duration) 3 yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. L. Reynolds M. D.
1914 (Address) Emmett Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds
In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pearl Idaho
DATE OF BURIAL: Nov 21 1914

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 1. 10M. 6-20-11. CERTIFICATE OF DEATH State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2641

County of Canyon Primary Registration District No. File No. 9382

City of Emmett (No. , St.) Registered No.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Hamilton G. Brock

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Dont know (Month) 1 (Day) (Year)

7. AGE: 89 about yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Vincent Brock

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Dawson
(Address) Emmett Ida

15.
Filed 11-28- 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to Oct 29 1914
that I last saw him alive on Oct 29 1914,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
I attended deceased ~~during~~ for a fractured hip which occurred June 10 last and from which he apparently recovered. He appeared well Oct 29. Death may have been due to hypostatic pneumonia
(Duration) yrs. mos. ds.
Contributory (Secondary) Fractured Hip
(Duration) yrs. 6 mos. ds.
(Signed) L. N. Cummings M. D.
Nov 21 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos ds In the State yrs mos ds.
Where was Disease contracted, If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Near Boise Idaho
DATE OF BURIAL: Nov 24 1914

20. UNDERTAKER: C. D. Buckmaster
ADDRESS: Emmett

1. Every item of information should be carefully supplied. Age should be stated EXACTLY. If unknown, CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 9383
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Woodland (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachel J Kenworthy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White.	Widow.

6. DATE OF BIRTH
October (Month) 22 (Day) 1840 (Year)

7. AGE
74 yrs. 1 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER William Reese

11. BIRTHPLACE OF FATHER (State or Country) Dont know.

12. MAIDEN NAME OF MOTHER Dont know.

13. BIRTHPLACE OF MOTHER (State or Country) Dont know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Loyd D Moon
(Address) Harrisburg Idaho

15.
Filed 11/28 1914 W. F. McNeal
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Rachel J Kenworthy 1914
Nov. (Month) 26 (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20th 1914, to Nov. 26th 1914, that I last saw her alive on Nov. 25th 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Pustulen Eczema
General Pyemia
Eczema
(Duration) 4 yrs. mos. ds.
Contributory (Secondary) and Age.
(Duration) yrs. mos. ds.
(Signed) O J Bryan M. D.
11/27 1914 (Address) Lamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane, Wash.	11/28 1914

20. UNDERTAKER	ADDRESS
C. J. Johnson	Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

File No. E 9384
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Felix Corbett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Indian	Married

6. DATE OF BIRTH
dont know (Month) 1 (Day) (Year)

7. AGE
about 91 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) dont know

12. MAIDEN NAME OF MOTHER dont know

13. BIRTHPLACE OF MOTHER (State or Country) dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel St Franck
(Address) Kamiah

15.
Filed 12/4/ 1914 W. F. McHaden Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Felix Corbett
Dec. (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19th 1914 to 19th 1914, that I last saw him alive on Nov. 19th 1914, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
.....
dont known
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Nephritis
(Secondary)
(Duration) 1 yrs. ..... mos. ..... ds.
(Signed) Ord Bayman M. D.
12/1 1914 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
O. J. Johnson	12/4 1914

20. UNDERTAKER	ADDRESS
Ind. Cemt No. 1	Kamiah Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

File No. 9385
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Frank

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: November 10th 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Head Child
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kamiah

10. NAME OF FATHER: Sam H Frank

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Priscilla Corbett

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam H Frank
(Address) Kamiah Idaho.

15. Filed 11/18 1914 W. F. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 15th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13th 1914, to 11/15th 1914, that I last saw h... alive on 11/15th 1914, and that death occurred on the date stated above, at 11:10 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis (Acute)

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Contusion of abdomen
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) C. S. H. Bryan M. D.
19.... (Address) Kamiah Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind Cemetery No. 1 | DATE OF BURIAL: 11/18 1914

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 9386
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Caribou
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Francis Collins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: August 14 1894 (Month) (Day) (Year)

7. AGE: 20 yrs. 2 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Edward W Farner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Francis Pullman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Edwin Jay Collins
(Address): Caribou Idaho

15. Filed 12/8 1914 W. J. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mrs Francis Collins 1914
Nov. (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 30 1914 to Nov. 3 1914, that I last saw h.. alive on Nov. 3 1914, and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) yrs. mos. 3 ds.
Contributory (Secondary) Puerperal Convulsions
(Duration) yrs. mos. 1 ds.

(Signed) C. J. Bryan M. D.
Nov. 5 1914 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Woodland — DATE OF BURIAL: Nov 8 1914

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

Primary Registration District No. 2019

File No. 9387

County of Boise

City of Garden Valley. (No. ....., ... St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME No name.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH

Dec (Month) 7 (Day) 1914 (Year)

7. AGE ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many 12 hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER John J. Scandlin

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Agnes Surikhark

13. BIRTHPLACE OF MOTHER (State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed Dec 10 1914 Mary Fitz Deputy.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1914, to Dec 7 1914, that I last saw her alive on Dec 7 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Unknown.

(Duration) 12 hrs. yrs. mos. ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. J. Fitz M. D.

Dec 7, 1914 (Address) G. J. Pleasants

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Garden Valley.	Dec 8 1914
20. UNDERTAKER	ADDRESS
Undertaker	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & SONS. 19760

Form V. S. No. 5 20m.

CERTIFICATE OF [redacted]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of Idaho City
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2019
(No. ....., ... St.)

File No. 9388
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1862 (Year)

7. AGE
62 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed Dec-10-1914 May Sit. Deputy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to never attended 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accident. Fell from Bridge and frozen when found.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Fitz M. D.
Dec 11 1914 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence: Usual Residence. Banner.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho City	Dec 1 1914
20. UNDERTAKER: Had none	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2019
File No. L 9389
Registered No. 25

1. PLACE OF DEATH.
County of Boise
City of Elsa.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Malloy.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Dec (Month) 23 (Day) 1867 (Year)

7. AGE
46 yrs. 11 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Dec - 10 - 1914 Mary Fitz Delph
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from neuralgia 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suicide by shooting.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Fitz M. D.
Dec 10 1914 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho City	Dec 3 1914
20. UNDERTAKER	ADDRESS
—	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Blaine
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 9300
Registered No. 13-
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 11 (Month) 5 (Day) 1914 (Year)

7. AGE: ___ yrs. ___ mos. ___ ds.
IF LESS than 1 day how many ..... hrs. or 1.0 min.

8. OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blaine Co.

10. NAME OF FATHER: Ira R Chaney

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Nellie A McFall

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira R. Chaney
(Address) Blaine

15. Filed 11- 6- 1914 D Partridge, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 1914, to ——— 1914 that I last saw him alive on 11- 5- 1914, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Cyst of Three Immature Triplets

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (Secondary)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) D Partridge, M. D.
11- 6 1914 (Address) Soldier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence. .....

19. PLACE OF BURIAL OR REMOVAL: Blaine, Ida
DATE OF BURIAL: 11- 6 1914

20. UNDERTAKER: Sig Mantle
ADDRESS: Fairfield

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9391

Registered No. 16

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Blaine
City of Soldier
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2138

2. FULL NAME Ida May Kiser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: [illegible] (Month) 28 (Day) 1714 (Year)

7. AGE: ..... yrs. 83 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Blaine Co. Ida

10. NAME OF FATHER: Jo Kiser

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: M E Osborn

13. BIRTHPLACE OF MOTHER (State or Country): Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Harvey
(Address) Soldier Ida

15.
Filed 11-15-1914 D P Higgs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-12 1914, to 11-15 1914
that I last saw her alive on 11-14 1914,
and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Lungs Dis
.....
.....
..... (Duration) ..... yrs. ..... mos. 5 - ds.

Contributory (Secondary) —
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D P Higgs M. D.
11-16 1914 (Address) Soldier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soldier Ida — DATE OF BURIAL: 11-16 1914

20. UNDERTAKER: Sig Mauld — ADDRESS: Fairfield

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 9392
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Near Nampa (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Hallom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 9 (Day) 1890 (Year)

7. AGE: 24 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J W Hallom

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Fannie Wheatley

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fannie Hallom
(Address) .....

15. Filed Dec 8 1914 W S Dobson Local Registrar
Emma Haguewood Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1914, to Dec 7 1914, that I last saw her alive on Dec 7 1914, and that death occured on the date stated above, [redacted] P. M.

The CAUSE OF DEATH* was as follows:
Fatty degeneration of heart with a thrombus and
Typhoid fever
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P L Payne M. D.
19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7/12 yrs ..... mos ..... days. In the State 7/12 yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cohlerlawn Cem	12-9 1914
20. UNDERTAKER	ADDRESS
F. T. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS., CHICAGO

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006.

File No. 9304

Registered No. .....

County of Canyon

City of Nampa (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hyrum Fouch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 55 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: David W Fouch

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Susan Reckenor

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H R Fouch
(Address) Parma Idaho

15. Filed Dec 4 1914 W R Delonge Local Registrar
Anna Hatfield Deputy

SYMS - YORK CO., PTRS. A 8685. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..... 191..., to ..... 191...,
~~that I last saw h~~ alive on ..... 191...,
and that death occured on the date stated above, at 12-15 A.M.

The CAUSE OF DEATH* was as follows:
Unknown

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F R Robinson Coroner M. D.

19.... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF ~~RESIDENCE~~ (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Star — DATE OF BURIAL: 12-5 1914

20. UNDERTAKER: F R Robinson — ADDRESS: Nampa

N. B.—Every item should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 1006

File No. 9395

County of Canyon

City of Nampa (No. ..., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susie May Ward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: April (Month) 15 (Day) 1895 (Year)

7. AGE: 19 yrs. 7 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: W W Russell

11. BIRTHPLACE OF FATHER (State or Country): Kan.

12. MAIDEN NAME OF MOTHER: Susie Wales

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C P Russell.
(Address) Boise Ida

15. Filed Dec 8 1914 S D Coburge M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914 to Dec 6 1914, that I last saw her alive on Dec 6 1914 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Haematemesis complicating pregnancy.

(Duration) 0 yrs. 0 mos. 15 ds.

Contributory (Secondary) Ulcer of Stomach.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. McKeen M. D.

12/8/1914 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE ~~OF BURIAL OR~~ REMOVAL: Boise Ida

DATE OF BURIAL: Dec 8 1914

20. UNDERTAKER: S B Shellabarger

ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9396
Registered No.

1. PLACE OF DEATH.
County of Bonner
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 3156
(No. ... St.)

2. FULL NAME John Person

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 22nd (Day) 1914 (Year)

7. AGE: ... yrs. ... mos. 2 ds.
IF LESS than 1 day how many ... hrs. or ... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Bonners Ferry Ida

10. NAME OF FATHER John Person

11. BIRTHPLACE OF FATHER (State or Country) Vermland Sweden

12. MAIDEN NAME OF MOTHER Stina Ericson

13. BIRTHPLACE OF MOTHER (State or Country) Vermland Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Person
(Address) Bonners Ferry, Ida

15. Filed Sept. 25th 1914 E. E. Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 25 th. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191..., that I last saw h... alive on ... 191..., and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Unknown —

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) E. E. Fry M. D.
9/25 1914 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry — DATE OF BURIAL: Sept. 25 1914

20. UNDERTAKER — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Bonner

Primary Registration District No. 3154

File No. 1934

City of Bonners Ferry (If not in incorporated limits, give township) No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Jacobs

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE 76 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed Oct. 14 — 1914 E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct. (Month) 14th. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 — 1914, to Oct. 14 — 1914, that I last saw him alive on Oct. 14 — 1914 and that death occurred on the date stated above, at 10? M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

..... (Duration) 1 yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry, M. D.

10/14/1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida. DATE OF BURIAL 10/16 1914

20. UNDERTAKER J. D. Moore ADDRESS Bonners Ferry Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Bonners Ferry (or)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79.
Primary Registration District No. 2156.

File No. 9398

Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth L. Franck Wood.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Oct. (Month) 14 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Bonners Ferry, Ida

10. NAME OF FATHER
Stanley Wood

11. BIRTHPLACE OF FATHER
(State or Country) Missoula Mont

12. MAIDEN NAME OF MOTHER
Grace E. Franck

13. BIRTHPLACE OF MOTHER
(State or Country) Bonners Ferry Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stanley Wood
(Address) Bonners Ferry Ida

15.
Filed Oct. 18th 1914. E. E. Fry. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct. (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15 1914, to Oct. 18th 1914, that I last saw h[im] alive on Oct. 15 1914, and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:
Uraemic Coooning.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Brierbach M. D.
10/7 1914 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ivan Mausr	10/19 1914

20. UNDERTAKER ADDRESS
John D. Mosse Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & SONS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 79.

County of Bonner Primary Registration District No. 2156.

City of Bonners Ferry (No. ....., ... St.) File No. 9363

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Harley Poston.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: August 20th 1831 (Month) (Day) (Year)

7. AGE: 83 yrs. 4 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Smith County Virginia

10. NAME OF FATHER: Elias Poston

11. BIRTHPLACE OF FATHER (State or Country): Smith County Virginia

12. MAIDEN NAME OF MOTHER: Sally H. Bellster

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elvon Poston
(Address) Bonners Ferry Ida

15. Filed Oct. 22nd 1914 E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct. 22nd 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1st 1914, to Oct. 22. 1914, that I last saw him alive on Oct. 21 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

General debility.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Sarcoma of leg.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.

10/22 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: 10/25 1914

20. UNDERTAKER: J. J. Moore ADDRESS: Bonners Ferry Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79.

County of Bonner

Primary Registration District No. 3156.

File No. 9400

City of

(No. ..... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jas. M. Thayer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 15th (Day) 1868 (Year)

7. AGE: 46 yrs. 7 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Erie Pennsylvania

10. NAME OF FATHER: A Thayer

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary J. Burgess

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm J M Thayer
(Address) Bonners Ferry Ida

15.
Filed Nov. 15 1914 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 13th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9th 1914, to Nov. 13th 1914, that I last saw him alive on Nov. 13th 1914, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Epithelioma
Internal injuries (?)
(Crushed by log)
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
11/13 1914 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caribou Valley Ida — DATE OF BURIAL: 11 15 1914

20. UNDERTAKER: E L Collins — ADDRESS: Bonners Ferry Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1104

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 3156

County of Boundary

City of Bonners Ferry (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willie Schwalbe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 9th (Day) 1890 (Year)

7. AGE: 25 yrs. 5 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: F. H. Schwalbe

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary Ellen Davis

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. M. Schwalbe
(Address) Bonners Ferry Idaho.

15. Filed Nov. 19th 1914. E. E. Irvine Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 1914, to Nov. 18 1914, that I last saw him alive on Nov. 18 1914 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Traumatic gangrene
(Gunshot wounds)

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. W. Kneebach M. D.

12/7 1914 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 11/19 1914

20. UNDERTAKER: J. J. Moore — ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 3156
File No. 9402
Registered No.

1. PLACE OF DEATH.
County of Boonen
City of Boonen Ferry Ida (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank H Gallas
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 17th (Day) 1 (Year)

7. AGE: 27 yrs. ..... mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lath Mill Work
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Frank Gallas

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Gallas
(Address) Boonen Ferry Ida

15.
Filed Dec. 1st. 1914 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
November (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Haemorrhage.
(Gunshot wound of femoral artery.) (accidental)
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
19.... (Address) Boonen Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boonen Ferry, Ida. DATE OF BURIAL: Dec. 1st. 1914

20. UNDERTAKER: John T. Moore ADDRESS: Boonen Ferry Ida

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9403
Registered No. 561

1. PLACE OF DEATH.
County of Bonner
City of Laclede

Registration District No. 78
Primary Registration District No. 2159
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Ross Burns

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: ..... 1 (Month) (Day) (Year)
7. AGE: 48 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Bartender
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Penn'
10. NAME OF FATHER: Unknown.
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. T. Burns
(Address) Edgemere Idaho
15.
Filed Dec 8 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 5 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 4 1914, to Nov. 5 1914, that I last saw him alive on Nov. 5 1914 and that death occurred on the date stated above, at 5:10 P.M.
The CAUSE OF DEATH* was as follows:
Gunshot wound of thorax
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. A. Allen M. D.
Nov. 5 1914 (Address) Laclede, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Laclede Ida.
DATE OF BURIAL: ..... 191...
20. UNDERTAKER: E M Brown
ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [illegible]
Registered No. 563

1. PLACE OF DEATH. Registration District No. 18
County of Bonner Primary Registration District No. 3153
City of Laclede (No. 6, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ewert West

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... 1 ..... (Month) (Day) (Year)

7. AGE: 28 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... mins

8. OCCUPATION
(a) Trade, profession or particular kind of work: Logger
(b) General nature of industry business or establishment in which employed (or employer): Lumbering

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Allen
(Address) Laclede

15.
Filed Dec 8 1914 P. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4 1914, to Nov. 6 1914
that I last saw him alive on Nov. 6 1914
and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:

Gunshot wound of thorax and abdomen

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. A. Allen M. D.
Nov. 6 1914 (Address) Laclede

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: 11/7 1914

20. UNDERTAKER: E. M. Brown — ADDRESS: S P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2159
(No. ....., ... St.)

File No. 9405
Registered No. 562
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME. Henry Dobbins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 3 (Day) 1845 (Year)

7. AGE: 69 yrs. 0 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Do

12. MAIDEN NAME OF MOTHER: Do

13. BIRTHPLACE OF MOTHER (State or Country): Do.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Dobbins
(Address) Clarks Fork Idaho.

15. Filed Dec 8 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1914, to Nov 6 1914, that I last saw him alive on Nov 5 1914, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Cardiac asthma
Mitral regurgitation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.
Nov 7 1914 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: 11/9 1914

20. UNDERTAKER: E M Brown
ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Westmond
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2159 Knapp St.
(No. ....., ... St.)

File No. 0402
Registered No. 364
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Margarete Lutzke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 7 (Day) 1914 (Year)

7. AGE: ~~4~~ yrs. 2 mos. ~~4~~ ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Joseph Lutzke

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Mary Ackl

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Lutzke
(Address) Westmond Idaho.

15.
Filed Dec 8 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs ..... mos. ..... ds.
(Signed) W M Knapp M. D.
11/17 1914 (Address) Hope Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was Disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Westmond — DATE OF BURIAL: 11/19 1914

20. UNDERTAKER: E V Brower — ADDRESS: Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2138
City of Sandpoint (No. ....., ... St.)
File No. 9407
Registered No. 666
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Sora Helen Lyons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S.G.
6. DATE OF BIRTH: Nov (Month) 12 (Day) 1914 (Year)
7. AGE: ..... yrs. ..... mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Bonner Co. Ida
10. NAME OF FATHER: Herbert Lyons
11. BIRTHPLACE OF FATHER (State or Country): [redacted] Iowa
12. MAIDEN NAME OF MOTHER: Angie Walker
13. BIRTHPLACE OF MOTHER (State or Country): Mo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. McKinnon
(Address) Sandpoint Ida
15.
Filed Dec 8 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 14 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1914, to Nov 14 1914
that I last saw her alive on Nov 14 1914,
and that death occurred on the date stated above, at 2P M.
The CAUSE OF DEATH* was as follows:
Premature birth 6½ mos
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. McKinnon M. D.
Nov 16 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: Nov 14 1914
20. UNDERTAKER: E M Brower — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boman
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78 Jackson
Primary Registration District No. 2138

File No. 940
Registered No. 3-65
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Ann Ames.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 21 (Day) 1854 (Year)

7. AGE: 59 yrs. 11 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Cook.
(b) General nature of industry business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Herbr.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Phoebe Montroy
(Address) Sandpoint Idaho.

15.
Filed Dec 8 1914 M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1913, to Nov 16 1914 that I last saw her alive on Fall of 1913; and that death occurred on the date stated above, at 3.30 a. M.

The CAUSE OF DEATH* was as follows:
Probably acute dilitation of heart-

(Duration) 15 minutes yrs. mos. ds.
Contributory (Secondary): Rheumatism with Mitral regurgitation
(Duration) Years yrs. mos. ds.

(Signed) R. E. Isaacson M. D.
19 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida.
DATE OF BURIAL 191

20. UNDERTAKER: E. W. Bowers
ADDRESS: SP

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

File No. 9[illegible]

County of Idaho

City of Grangeville (No. ....., ... St.)

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chloe R Ingram

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: May 30 (Month) (Day) 1868 (Year)

7. AGE: 46 yrs. 5 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oakland Cal

10. NAME OF FATHER: John Tipton

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Rachel Huggins

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ingram
(Address) Grangeville Ida.

15. Filed Nov 24 1914 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 24 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914 to Nov 24 1914 that I last saw her alive on Nov 3 1914 and that death occurred on the date stated above, at 6a. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Pelvic Organs —
don't know
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G B Stockton M. D.
Nov 25 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Nov 27 1914

20. UNDERTAKER: W E Graham — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
File No. 9444
Registered No. 44
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clay Columbus Jesse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: May (Month) 12 (Day) 1846 (Year)

7. AGE: 68 yrs. 6 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: don't Know

11. BIRTHPLACE OF FATHER (State or Country): don't Know

12. MAIDEN NAME OF MOTHER: don't Know

13. BIRTHPLACE OF MOTHER (State or Country): don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P A Jesse
(Address) Grangeville Ida,

15. Filed Dec 1 1914 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1914 to Nov 24 1914 that I last saw him alive on Nov 14 1914 and that death occurred on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Carcinoma of throat

(Duration) don't Know yrs. mos. ds.

Contributory (Secondary)

(Duration) 8 yrs. mos. ds.

(Signed) G S Stockton M. D.
Nov 24 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Nov 25 1914

20. UNDERTAKER: W E Graham — ADDRESS: Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 2181

File No. 9411

Registered No. 46

County of Idaho

City of Elk City (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Anna Parr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: June (Month) 7 (Day) 1847 (Year)

7. AGE: 67 yrs. 5 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Proprietor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: John Kinney

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. L. L. Bassett
(Address) Elk City, Idaho

15.
Filed dec 9 1914 G L Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 25 (Day) 1914 (Year) 191

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw her alive on Nov. 25 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure
(Sud dead, No physician called, 75 miles to nearest doctor

(Duration) 4,8,8 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Elk City, Idaho

DATE OF BURIAL: Nov. 26, 1914

20. UNDERTAKER: None

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 9413
Registered No. 25

1. PLACE OF DEATH.
County of Elmore
City of Prairie, Idaho (No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm H Rudge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 29th (Day) 1849 (Year)

7. AGE: 64 Yrs. 8 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer and stock grower
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ills.

10. NAME OF FATHER Wm. Rudge

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Marion A Rudge Prairie Ida.

15. Filed Nov. 22nd 1914 Burnaltes Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 20th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Heart trouble-valvular
- sudden
(Duration) about two Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H. H. Easton M. D.
11/22 1914 (Address) Lowman Boise Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie Ida — DATE OF BURIAL: 11/22 1914

20. UNDERTAKER: M. T. Rudge — ADDRESS: Prairie, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 941

Registered No. 62

1. PLACE OF DEATH.
County of Franklin
City of Preston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cornelius Pender Cherry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov 17 1878 (Month) (Day) (Year)

7. AGE: 36 yrs. 0 mos. 1 ds.
IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Centerville Utah

10. NAME OF FATHER: Joseph S. Cherry

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Ellen Pender Cherry

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Abbie Cherry
(Address) Preston Idaho

15.
Filed NOV. 25 1914 D. Allen Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 18 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Nov. 18 1914, that I last saw h[illegible] alive on Nov 18 1914, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 4 yrs. 4 mos. 4 ds.

Contributory (Secondary)

(Duration) 9 yrs. 9 mos. ds.

(Signed) G. W. Slater M. D.
Nov. 19 1914 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191...

20. UNDERTAKER: W. A. Gilmore | ADDRESS: Preston

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2119
(No. ..... St.)

File No. 945
Registered No. 58

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Hammond Campbell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
Sept. (Month) 3 (Day) 1914 (Year)

7. AGE
4 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Preston

10. NAME OF FATHER Martin H. Campbell

11. BIRTHPLACE OF FATHER
(State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Oreta M. Porter

13. BIRTHPLACE OF MOTHER
(State or Country) Orderville Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M H Campbell
(Address) Preston Idaho.

15.
Filed Dec. 8 1914 Allen R Rutter
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. Dec. (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2 1914, to Nov. 3 1914, that I last saw him alive on Nov. 2 1914, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) —
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Allen R Rutter M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	11/4 1914

20. UNDERTAKER	ADDRESS
W. A. Skidmore	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Archer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. .....
Registered No. 68
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Belva Margaret Beck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: Nov 15 1914
(Month) (Day) (Year)

7. AGE: — yrs. — mos. 17 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Clarence Beck

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Margaret Briggs

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha Wrides
(Address) Archer, Ida

15.
Filed 12-2 1914 G G Eakle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 2 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at —M.

The CAUSE OF DEATH* was as follows:
Erysipelas

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) No physician M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted *if not at place of death?* .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Archer, Ida
DATE OF BURIAL: 12-3 1914

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FILE # 9417

YEAR 1914

IDAHO DEATH CERTIFICATE

VOID SEE STILLBIRTH
s 1914-9417

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 941

Registered No. 66

County of Madison

City of Independance (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrina B. Thomason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH

Sept (Month) 1 (Day) 1853

~~Nov~~ (Month) ~~16~~ (Day) ~~1914~~ (Year)

7. AGE

61 yrs. 3 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Jens Olson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER ~~Johans~~ Anna D. Johansen

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charley Thomason

(Address) Independance Rey. #1

15. Filed 11-17 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Unknown. Seemed to be fairly well on going to bed, but was found dead in morning

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan, Utah

DATE OF BURIAL: Nov 20 1914

20. UNDERTAKER: John Phillips

ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. (illegible)
Registered No. 10

1. PLACE OF DEATH. Registration District No. 4 8
County of Lemhi Primary Registration District No. 2127
City of Winchester (No. ....., (First Twin) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorfaut Wynne

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct 3rd 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. 1 mos. 3 ds.
If LESS than 1 day how many ..... hrs. or min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Winchester, Idaho

10. NAME OF FATHER: W. H. Wynne

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Rosa Rudwell

13. BIRTHPLACE OF MOTHER (State or Country): Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Rosa L. Wynne

15. Filed 11-10-1914 Elbert R. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 6th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Died 191..., to ..... 191...
that I last saw h... alive on attended 191...
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Marasmus

..... (Duration) ..... yrs. 1 mos. 3 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elbert R. Rogers M. D.
11-6-1914 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 11-7-1914
20. UNDERTAKER: none — ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 48

County of Lewis Primary Registration District No. 2127

City of Winchester (No. (Record Town) St.)

File No.

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Wynne

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH Oct 3rd 1914
(Month) (Day) (Year)

7. AGE yrs. 1 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Winchester Idaho

10. NAME OF FATHER W. H. Wynne

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Rose Kidwell

13. BIRTHPLACE OF MOTHER (State or Country) Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. D. Thompson
(Address) .....

15.
Filed 11-13-1914 Elbert B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 13th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 191..., to ..... 191.....
that I last saw him alive on Nov 191....
and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration) ..... yrs. 1 mos. 10 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elbert B. Rogers M. D.
11-13- 1914 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 11-14-1914

20. UNDERTAKER: None — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of
City of
Registration District No. 1325
Primary Registration District No. 2305
(No. , St.)
File No. (1722)
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie Lillie Kemp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1 14 (Year)

7. AGE: — yrs. 1 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ollie Kemp

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Ida Kosti

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): James R Kemp
(Address):

15. Filed Nov 30 1914 H. S. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1914, to Oct 5 1914, that I last saw her alive on Oct 5 1914 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia — 8 days

(Duration) yrs. mos. ds.

Contributory (Secondary) Erysipelas

(Duration) yrs. mos. 20 ds.

(Signed) James R Kemp M. D.

10/5 1914 (Address) Murray Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Ward Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Mullan

Registration District No. 122
Primary Registration District No. 2285
(No. ....., ... St.)

File No. 914
Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mae Dauchy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W	widow

6. DATE OF BIRTH ..... (Month) ..... (Day) 1860 (Year)

7. AGE 54 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Wm Root

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: A. A. Root

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Nov 30 1914 — W. F. Mowery, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1914, to Sept 10 1914, that I last saw h er alive on Sept 10 1914 and that death occurred on the date stated above, at 12 15 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

..... (Duration) — yrs. — mos. 8 hrs ds.

Contributory (Secondary) Chronic Constipation

..... (Duration) 25 yrs. ..... mos. ..... ds.

(Signed) James R Dean M. D.

Sept 10 1914 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Ward Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

Primary Registration District No. 2 B

File No. 9424

County of Shoshone

City of Burke (No. Below Mace School on St. Track)

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 19 (Day) 1914 (Year)

7. AGE: ....yrs. ....mos. ....ds.

IF LESS than 1 day how many 6 hrs. or 20 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shoshone Co

10. NAME OF FATHER: W. W. Calvert

11. BIRTHPLACE OF FATHER (State or Country): S. Dakota

12. MAIDEN NAME OF MOTHER: Fannie Pierson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Calvert
(Address) Burke

15. Filed Nov 20 1914 T. A. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19 1914, to Nov. 19 1914, that I last saw him alive on Nov. 19 1914, and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. Bruce M. D.

Nov 19 1914 (Address) Burke, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Nov 19 1914

20. UNDERTAKER: Bruce G Mostell — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 942

Registered No. 45

1. PLACE OF DEATH.

County of Ada

City of

Registration District No. 8

Primary Registration District No. 2004

(No. Near Main St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nina M. Hesse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb. (Month) 12 (Day) 1848 (Year)

7. AGE: 66 Yrs. 8 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Louis Mo.

10. NAME OF FATHER William Mossberger

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unbekannt

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conr F. Hesse

(Address) Boise Ida.

15. Filed 11-5 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH About October 30 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead Nov 5 1914, to ~~191~~, ~~that I last saw h alive on 191~~, and that death occured on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:

Accidental Burns was last seen alive Oct 30-1914 Body recovered Nov 4-1914

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Adolph Schreiber M. D.

19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: Oct. 6 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 9425
Registered No. 46

1. PLACE OF DEATH.
County of Ada
City of near Boise
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles W See
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. (Month) Feb (Day) 2 (Year) 1833

7. AGE: 81 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: David See

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Lunstrum
(Address) Boise, R. D. 2

15. Filed 11 - 9 191 4
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910, to 1914, that I last saw him alive on Nov. 2 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pellagra

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. ..... mos. ..... days In the State..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov 9 1914
20. UNDERTAKER: Terry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9427
Registered No. 47

1. PLACE OF DEATH.
County of Ada
City of Boise
Registration District No.
Primary Registration District No.
(No. 1 Mile So of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John T. Schneider

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 9 (Day) 1873 (Year)

7. AGE: 41 yrs. 7 mos. 15 ds.
IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Johnsonk. Pa.

10. NAME OF FATHER: Thos Schneider

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Anna Shlaider

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Effie Schneider
(Address) Boise

15.
Filed 11-25 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1914, to Nov 25 1914, that I last saw him alive on Nov 24 1914 and that death occurred on the date stated above, at 11-45 P.M.

The CAUSE OF DEATH* was as follows:
Tumor of Brain

(Duration) yrs. 3 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Edward J Bruce M. D.
Nov 25 1914 (Address) 208 Sonna Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Ada County Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery
DATE OF BURIAL: 11/27 1914

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 91

Registered No. 268

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 408 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis McCandless

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Not Known (Month) (Day) 1 (Year)

7. AGE 61 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... retired

(b) General nature of industry, business, or establishment in which employed (or employer)... Laborate of Ada Co Poor Farm

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Malinda Shuntz

(Address) ...

15. Filed 11-5 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1914, to Nov 2, 1914, that I last saw h... alive on Oct 2nd 1914 and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Tuberculosis Pulmonal Chronic

... (Duration) 1 Yrs. ... mos. ... ds.

Contributory (Secondary) ...

... (Duration ... yrs. ... mos. ... ds.

(Signed) R. E. Shuntz M. D.

19... (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 20 days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery County Plot — DATE OF BURIAL 11/5 1914

20. UNDERTAKER Schreiber & Sidenfaden — ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 10074

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. 270

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1411 East Washington St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard C. Hart

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 11th (Day) 1839 (Year)

7. AGE: 75 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)... Express messenger

9. BIRTHPLACE (State or Country) Henderson, N.Y.

10. NAME OF FATHER Davis Hart

11. BIRTHPLACE OF FATHER (State or Country) Conn

12. MAIDEN NAME OF MOTHER Trifere Edmer

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. E. Jayman

(Address) 1415 E. Jefferson St

15.

Filed 11—5 1914

M S Parks
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 5th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1914, to Nov 3 1914, that I last saw h... alive on ... 191..., and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration ... yrs. ... mos. ... ds.

(Signed) Geo. Burt M. D.

19.... (Address) ...

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence 1411 E. Wash St. Boise Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/6 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

BYRUS - YORK CO., PTRS. & BDRS. 24658

Nugman

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 914
Registered No. 271

1. PLACE OF DEATH.
County of Ada.
City of Boise
(No. 1312 N. 6 St.) St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Cylia Dufaut Cobley.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH. October 16 1914
(Month) (Day) (Year)

7. AGE ... Yrs. ... Mos. 21 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James V. Cobley.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Laura Warner

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): James H. Cobley
(Address): 1312 N. 6

15. Filed 11-6 1914
M S Parker
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 6 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16th 1914, to Nov 6th 1914, that I last saw her alive on Nov 5th 1914, and that death occured on the date stated above, at 12.50 P.M.

The CAUSE OF DEATH* was as follows:
Mal assimilation — failed gradually from birth.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Premature birth
Duration ... yrs. 7 months mos. ... ds.
(Signed) J W Taylor M. D.
11-6-1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: Nov 6 1914

20. UNDERTAKER: Fry & Summers. ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 9431
Registered No. 272

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 317 N. 9th St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Noble

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR, DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Oct (Month) 19 (Day) 1844 (Year)
7. AGE: 70 Yrs. — Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Capitalist
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: John Noble
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Mary Mossop
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robt Noble Jr
(Address) Boise Idaho
15.
Filed 11—7 1914
M S Parker
Local Registrar

SVMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1914, to Nov 5 1914, that I last saw h... alive on Nov 5 1914, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Diabetes

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Gustin M. D.

11/7 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Cemetery — DATE OF BURIAL: Nov. 8 1914

20. UNDERTAKER: Schreiber & Kiedrowski — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. (illegible)

County of Ada

City of Boise (No. 410 State St.)

Registered No. 274

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Jarod Byers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 13 (Day) 1840 (Year)

7. AGE: 74 Yrs. ... Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: John Byers

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. J. Byers

(Address) Boise R.D.

15.

Filed 11-10 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from (illegible) 1913, to Nov 8 1914, that I last saw h... alive on Nov 8 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Brights disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo Coleste M. D.

19.... (Address) Boise

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence near Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov. 11 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 9433
Registered No. 276

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lau Poy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year) 874

7. AGE: 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address)

15. Filed 11-12 1914 W. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1914, to Nov 9 1914, that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Fr Cacciola M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 1 days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Cemetery — DATE OF BURIAL: 11/12 1914
20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 11 N Main St.)

File No. [illegible]

Registered No. 279

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. E. McKinney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. [illegible] (Month) ..... 1 (Day) ..... (Year)

7. AGE: about 75 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Unobtainable

11. BIRTHPLACE OF FATHER (State or Country): a a

12. MAIDEN NAME OF MOTHER: a a

13. BIRTHPLACE OF MOTHER (State or Country): a a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. W. Pastor

(Address) Weiser

15.

Filed 11-17 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 191..., to ..... 191...,

that I last saw h[illegible] alive on ..... 191...

and that death occured on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows:

Sudden death -

Found dead in the chair at Idaho Hotel Room 6

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. McKinney M. D.

19.... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Weiser, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: 11/18 1914

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2
County of Ada — Primary Registration District No. 1524
City of Boise (No. 1134 N 18th St.) File No. 9435
Registered No. 283

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Peacock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: Dec 29th (Month) (Day) 1829 (Year)
7. AGE: 84 yrs. 10 mos. 27 ds. IF LESS than 1 day how many.....hrs. or .....mins
8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Yorkshire England
10. NAME OF FATHER: J. Peacock
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: not obtainable
13. BIRTHPLACE OF MOTHER (State or Country): not obtainable
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W M Hammer
(Address) 1939 N 18
15. Filed 11-25 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 25th (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1914, to Nov 25 1914
that I last saw him alive on Nov 24 1914
and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:
Arterio sclerosis & Chronic Nephritis
(Duration) 5 yrs. mos. ds.
Contributory Uraemia
(Secondary)
(Duration) yrs. mos. 5 ds.
(Signed) Thomas N. Braxton M.D.
Nov 25 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: 11/26 1914
20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17143

Dr. Braxton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [redacted] M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF [redacted]TH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

File No. 94

City of Boise

(No. 1 E Alphonsus St.)

Registered No. 283

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Perry Belmont Fry-

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.) Married

6. DATE OF BIRTH. July (Month) 13 (Day) 1887 (Year)

7. AGE [redacted] Yrs. 7 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lucas Co Iowa

10. NAME OF FATHER Lindsphillip Fry-

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Laura N Hill-

13. BIRTHPLACE OF MOTHER (State or Country) Vermont Iowa

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) Manuel P. Fry
(Address) Eagle Ida R F D no 1

15.
Filed 11-27 1914 M S Parker Local Registrar

SYMS - YORK CO., PTRS. & ADMS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 [redacted] 1914, to Nov 25 1914, that I last saw [redacted] alive on Nov 25 1914, and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... Yrs. ..... mos. 3 wks. ..... ds.

Contributory (Secondary) Perforation Typhoid

(Duration) ..... Yrs. ..... mos. 17 hrs. ..... ds.

(Signed) O E Hall M. D.

19..... (Address) Star Idaho,

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos. 17 days

Where was disease contracted if not at place of death? Harris Creek Idaho

Former or usual residence Harris Ranch

19. PLACE OF BURIAL OR REMOVAL: Star Idaho — DATE OF BURIAL: Nov 27 1914

20. UNDERTAKER: [redacted] — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 819 N 18 St. St.)
Registration District No. 2
Primary Registration District No. 1004
File No. 14
Registered No. 285
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ford Newton Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug 17 (Month) (Day) 1914 (Year)

7. AGE: Yrs. 3 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER Willis E Sullivan

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Helen I. Ford

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Willis E. Sullivan
(Address) 819 N. 18th. Boise Ida

15.
Filed 11 - 28 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 28" (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25, 1914, to Nov 28 1914, that I last saw h[illegible] alive on Nov 28 1914, and that death occured on the date stated above, at 3.30a M.

The CAUSE OF DEATH* was as follows:
Sanitarium
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Smith M. D.
11/28 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Nov 29 1914

20. UNDERTAKER: Frye & Summers | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 287 286
Registered No. 9438

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 231, Warm Spring ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Elizabeth Sargent

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: February 20th (Month) (Day) 1888 (Year)

7. AGE: 26 yrs. 9 mos. 8 ds. IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan, Utah

10. NAME OF FATHER: Gustave Lundberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Alice Smith

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Alice L. Roberts
(Address): 335 West 1 No Street Logan Utah

15.
Filed Nov. 29th, 1914. E. B. Cahoon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 28th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1914, to Nov. 28 1914
that I last saw her alive on Nov. 28 1914
and that death occurred on the date stated above, at 11:30 p. M.

The CAUSE OF DEATH* was as follows:
Septicemia (Puerperal)

.....(Duration) .....yrs. .....mos. 7 ds.
Contributory
(Secondary)
.....(Duration) .....yrs. .....mos. .....ds.

(Signed) W. F. Tuckey M. D.
Nov. 29 1914 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence Mountain Home Idaho.

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: 11/29 1914

20. UNDERTAKER: Schreiber & Sidenman — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Avon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ... St.)

File No. 1 [illegible]
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Silas Mervin Hanford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Dec. (Month) 6 (Day) 1878 (Year)

7. AGE: 35 yrs. 11 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: laborer
(b) General nature of industry business, or establishment in which employed (or employer): woodcutter

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: Hiram Hanford

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Emma Lloyd

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. C. Faust
(Address) Deary

15. Filed 11/10 191 4 P. C. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occurred on the date stated above, at abt. 2:30 P.M.

The CAUSE OF DEATH* was as follows:
accidental — from ax in his hand striking his head.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

11/10 1914 (Signed) P. C. Faust M. D. (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Avon Cemetery | DATE OF BURIAL: 11/12 1914

20. UNDERTAKER: J. E. Pickard | ADDRESS: Deary

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 9411
Registered No. 52
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William L Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~ Widower

6. DATE OF BIRTH: January 16" 1 (Month) (Day) (Year)

7. AGE: 73 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Placer Mining
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Donot know.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Sarah A. Rees
(Address) 1007 E. Galena St Butte Mont

15.
Filed NOV 26 1914 191
Helen L Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
November 25" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 25th Nov 1914, to 25th Nov 1914, that I last saw him alive on 25th Nov 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Edema of Lungs - Last saw him before death two days was a case of Valvular heart disease -
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. J. Wright M. D.
25 Nov 1914 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Butte Montana | DATE OF BURIAL: 11-29" 1914

20. UNDERTAKER: W C Hoebler | ADDRESS: Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 94
Registered No. 53
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pleasant T Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: October 8th (Month) (Day) 1851 (Year)

7. AGE: 63 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner and Prospector
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Wiley Rose

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Shalet Harris

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wiley J. Rose
(Address) Leesburg Idaho

15.
Filed DEC -8 1914 191.. Helen L Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December 8th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1914, to Dec 8th 1914, that I last saw him alive on Dec 5 1914, and that death occurred on the date stated above, at 6 10 A.M.

The CAUSE OF DEATH* was as follows:
Brights Disease (Chronic)

..... (Duration) Seven yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Whitwell M. D.
Dec 8 1914 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 12-9" 1914

20. UNDERTAKER: Wm C Hoobler — ADDRESS: Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 23

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 122

Primary Registration District No. 2201

County of Shoshone

City of Kellogg (No. ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eli Labus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Servian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Write the word.~~ M

6. DATE OF BIRTH: — — 1892
(Month) (Day) (Year)

7. AGE: 22 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Dan Labus

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mika

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(Address) George Savich, Kellogg Idaho

15.

Filed Nov 29 1914 Geo. J. Lasher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 22, 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h____ alive on ____ 191__, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Mine accident
Crushed between cars and ore Chute.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) no doctor M. D.

19__ (Address) ____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho — DATE OF BURIAL: Nov 24, 1914

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg

L. E. # 127

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1V3

Primary Registration District No. VV01

File No. V4

County of Shoshone

City of Kellogg

(No. ..., ... St.)

Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Vaughn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	married

6. DATE OF BIRTH: Oct. (Month) 9 (Day) 1843 (Year)

7. AGE: 21 yrs. — mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laundry Driver
(b) General nature of industry business, or dstablishment in which employed (or employer): Teamster

9. BIRTHPLACE (State or Country): Clinton, Indiana

10. NAME OF FATHER: James Vaughn

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sadie Joyner

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Gerner
(Address) Kellogg, Idaho

15.
Filed Nov 29th 1914 Geo. J. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191..., that I last saw h~~im~~ alive on ... 191..., and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Accident Shot twice through the lungs.

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. R. Mason M. D.

11/23 1914 (Address) Kellogg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho | DATE OF BURIAL: Nov. 15, 1914

20. UNDERTAKER: M. C. Thornhill | ADDRESS: Kellogg

L.E. #127

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 173
Primary Registration District No. 2201
(No. ....., ... St.)

File No. 75
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida May Corbe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Femal	White	Single

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1897 (Year)

7. AGE: 17 yrs. 1 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolgirl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Corbe

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Eliza H. Baker

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred D Corbe
(Address) Kellogg, Idaho

15.
Filed 11/27 1914 Geo S Tesher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 28 (Day), 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.r alive on Oct 28 1914
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Mason M. D.
11/23 1914 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg Idaho	Oct 30, 1914
20. UNDERTAKER	**ADDRESS**
M. C. Thornhill	Kellogg, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12 m

County of Shoshone

Primary Registration District No. 1201

File No. 76

City of Kellogg (No. ....., ... St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Chester Mason

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: Sept (Month) 3 (Day) 1902 (Year)

7. AGE: 12 yrs. 2 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Peter Mason

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Miss Fuller

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charlotte Thomson

(Address) Kellogg Idaho

15.

Filed 11/29/ 1914 Geo. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

accidently shot through the lungs by another Boy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Mason M. D.

11/23 1914 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho — DATE OF BURIAL: Nov 9, 1914

20. UNDERTAKER: W. C. Thornhill — ADDRESS: Kellogg Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone — Registration District No. ____ — File No. ____

City of Wardner — Primary Registration District No. ____ — Registered No. ____

(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ____ ____ Rowe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 3 (Day) 1914 (Year)

7. AGE: Infant. Yrs. ____ Mos. ____ ds. ____

IF LESS than 1 day how many ½ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... ____

(b) General nature of industry, business, or establishment in which employed (or employer)... ____

9. BIRTHPLACE (State or Country) Wardner Idaho.

10. NAME OF FATHER R. G. Rowe

11. BIRTHPLACE OF FATHER (State or Country) Mich

12. MAIDEN NAME OF MOTHER Elizabeth Stock

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) ____

15. Filed Oct 9th 1914 Geo. S. Lesher, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1914, to ____ 191__, that I last saw him alive on Oct 3 1914, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) H. C. Lindsay M. D.

Oct 6. 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Kellogg Ida — DATE OF BURIAL: Oct 5 191__

20. UNDERTAKER: M. C. Hazlewood — ADDRESS: Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOBS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2711
Registered No.

1. PLACE OF DEATH. Registration District No. 123
County of Shoshone Primary Registration District No. 2201
City of Kellogg (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Knute Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 3 (Day) 1914 (Year)

7. AGE: 0 yrs. 0 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry business or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Kellogg Idaho.

10. NAME OF FATHER: Ole Nelson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Sandra Tipalus

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex D. McCracken M.D.
(Address) Kellogg Idaho.

15. Filed Dec 10 1914 Geo. A. Fosher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1914, to Nov 15 1914
that I last saw him alive on Nov 14 1914
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Acute Enteritis

..... (Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alex D. McCracken M. D.
Nov 19 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg — DATE OF BURIAL: Nov 16 1914

20. UNDERTAKER: Undertaker — ADDRESS: Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

ACE OF DEATH

Registration District No. 123

Primary Registration District No. 2201

File No. 78

Cou... Shoshone

City of Kellogg (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Richard Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: ..... 1 .....
(Month) (Day) (Year)

7. AGE: 28 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Richard Williams

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Lydia Griffiths

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed DEC 10 191 4 Geo. A Lesher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 24 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Result accident - falling ore in a Chute.

(Duration) Instantly yrs. ..... mos. ..... ds. Killed

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alex G. W. Cracken M. D.

Dec 1914 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg, Idaho	Nov 29, 1914

20. UNDERTAKER	ADDRESS
M. C. Thomkins	Kellogg

L. E. #127

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 123

Primary Registration District No. 7701

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 76

Registered No. .....

1. PLACE OF DEATH.

County of Shoshone

City of Cataldo

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vilgan Ranhala

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
mal	white	married

6. DATE OF BIRTH. — — 1 (Month) (Day) (Year)

7. AGE 73 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... no information

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER no information

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER no information

13. BIRTHPLACE OF MOTHER (State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Dalah

(Address) Cataldo Idaho

15. Filed 12/10 191 4 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about Aug 30, 191 3
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Found dead, been dead
many a year

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

(Duration ... yrs. ... mos. ... ds.

(Signed) no doctor M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cataldo Idaho	Dec 9, 1914

20. UNDERTAKER	ADDRESS
M. C. Thornhill	Kellogg, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 94

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Obstarczyk

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1866 (Year)

7. AGE
48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Austria

10. NAME OF FATHER: Joe Obstarczyk

11. BIRTHPLACE OF FATHER
(State or Country) Austria

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER
(State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jack Obstarczyk.
(Address) Nampa Ida

15.
Filed Dec 2 1914 D V S O Canyon Co
Local Registrar
Notified Dr. R. T. Robinson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 30 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..... 191..., to ..... 191...,
that ~~I~~ last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Fracture of Skull
(Accidental)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) T. S. Robinson Coroner M. D.
19.... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida
DATE OF BURIAL: 12-2 191 4

20. UNDERTAKER: Nampa
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. PTG. & MFG. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. [illegible]

County of Cassia

City of Burley

(No. ....., ... St.)

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lettie L. Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: April (Month) 3 (Day) 1878. (Year)

7. AGE: 36 yrs. 7 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Christopher Merkley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lettie Allred

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Bennett
(Address) Burley Idaho.

15.
Filed Nov 10th 1914 W. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 9th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-26" 1914, to 11-8- 1914, that I last saw her alive on Nov 8 1914, and that death occurred on the date stated above, at 10:30 a. M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... yrs. 3 wks mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Evans M. D.

19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Nov. 11th. 1914

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

File No. 94

Registered No. 42

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 20 (Day) 1850 (Year)

7. AGE: 64 yrs. 9 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Milton Baker

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Melissa J Kelsey

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. L. Barclay

(Address) Burley Ida

15.

Filed Nov 3rd 1914 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 2nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from died and Early 191, that I last saw h..... alive on ..... 191, and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Trouble.

several years.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

11-3-'14 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley, Ida — DATE OF BURIAL: 11-6-14 191

20. UNDERTAKER: L. B. Gallegly — ADDRESS: Burley, Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. 41

County of Cassia

City of Albion (No. ....., ... St.)

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Heneny E. Bange

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 14 (Day) 1857 (Year)

7. AGE: 57 yrs. ..... mos. 22 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Custodian of grounds
(b) General nature of industry business, or dstablishment in which employed (or employer): and buildings Albion State Normal

9. BIRTHPLACE (State or Country): Bonneville California

10. NAME OF FATHER: Daniel L. Bange

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Sarah Howe

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas H. Bange.
(Address) Albion Idaho.

15.
Filed Nov 7th 1914 W. J. Ballenger Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Heart Failure

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Gallogly / Coroner / M. D.

Nov. 7 1914 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida — DATE OF BURIAL: Nov. 10th 1914

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

File No.

City of Burley

(No. ....., ... St.)

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Herman Hanson.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: Oct. 5 1913 (Month) (Day) (Year)

7. AGE: 1 yrs. 1 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: Oscar Hanson

11. BIRTHPLACE OF FATHER (State or Country): Utah Co. Utah

12. MAIDEN NAME OF MOTHER: Ann Wallwork.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Hanson
(Address) Burley Route 2

15.
Filed Nov. 24th 1914 W. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 23 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-ember 18 1914, to Nov 23 1914, that I last saw h~~is~~ alive on November 22 1914, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Uremic Convulsions

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John M. Hunter M. D.

Nov 23 1914 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Ida. | DATE OF BURIAL: Nov 25 1914

20. UNDERTAKER: Bishop Reeder | ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of Kimberley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 2085

(No. ....., ... St.)

File No. 94

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira M. Shoemaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 12 (Day) 1912 (Year)

7. AGE: 2 yrs. mos. 2 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farming.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wyoming.

10. NAME OF FATHER: Jas. H. Shoemaker

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Mayd Green.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. H. Shoemaker.
(Address) Kimberley, Idaho.

15. Filed Nov. 4 1914 John A. Engle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 24 1914, to November 3 1914, that I last saw h er alive on November 2 1914 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) ..... yrs. ..... mos. 12 ds.

Contributory (Secondary) abrasion of skin

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Morgan M. D.

Nov. 4 1914 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Nov. 4 1914

20. UNDERTAKER: J. J. Grossman — ADDRESS: Twin Falls

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls. Registration District No. 37
City of [illegible] Primary Registration District No. 1085
(No. ....., ... St.)
File No. 94
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilbert Klingemann

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 29 (Day) 1909 (Year)

7. AGE: 4 yrs. 11 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Louis Klingemann

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Louise Finke

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible] Idaho
(Address) Louis Klingemann

15. Filed Nov. 29 1914 John Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1914, to Nov 28 1914, that I last saw him alive on Nov 28 1914, and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T.O. Boyd M. D.
19 ..... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Hansen
Former or usual residence Hansen

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: Nov. 30 1914

20. UNDERTAKER: [illegible] Boseman | ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of ....
(No. ...., ... St.)
Registration District No. 37
Primary Registration District No. 1086
File No. 9459
Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Roantree

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 20 1844
(Month) (Day) (Year)

7. AGE: 70 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miller
(b) General nature of industry, business, or establishment in which employed (or employer): Flour mill

9. BIRTHPLACE (State or Country): Middleton, England

10. NAME OF FATHER: John Roantree

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Roantree (nee Roantree)

13. BIRTHPLACE OF MOTHER (State or Country): Middleton, England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jennie Roantree Bowsides
(Address) 319-7th Ave. E., Twin Falls, Ida.

15. Filed Nov. 19 1914
Robert Coughlin
Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24655

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November 18th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3 1914, to Nov. 17 1914, that I last saw him alive on Nov 17 1914 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease.
Dropsy
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary) ....
(Duration) .... yrs. .... mos. .... ds.

(Signed) C. D. Weaver M. D.
11/19 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State ....yrs....mos....days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 11-20 1914

20. UNDERTAKER: Chas J Crosby
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 3401
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Lavern Cummings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH
Jan 18 1891
(Month) (Day) (Year)

7. AGE
23 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wash.

10. NAME OF FATHER J W. Cummings

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Minnie Witaker

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Minnie Cummings
(Address) Tacoma Wash

15.
Filed Nov. 3 1914 John P Coughs
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov. 2 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29 1914, to Nov. 2 1914, that I last saw h[illegible] alive on Nov 2 1914, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(Duration) ..... yrs. 1 mos. 4 ds.
Contributory (Secondary) Hemorrhage from bowels
(Duration) ..... yrs. 1 mos. 3 ds.

(Signed) J. W. Wilson M. D.
Nov 3 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Olympia Wash. DATE OF BURIAL: .....191..

20. UNDERTAKER: Chas J Crosby ADDRESS: Twin Falls

Dr U Case

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 0[illegible]
Registered No. 48
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daisy Poole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	

6. DATE OF BIRTH: May (Month) 30 (Day) 1908 (Year)

7. AGE: 1 yrs. 2 mos. 21 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John Poole

11. BIRTHPLACE OF FATHER (State or Country): Holland.

12. MAIDEN NAME OF MOTHER: Inza Kuratt.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jno Poole
(Address) Nezperce Ida

15. Filed Nov 30 1914 J M Faith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1914 to Aug 20 1914 that I last saw her alive on Aug 20 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
acute intestinal obstruction

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle W Howard M. D.
19..... (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce, Ida — DATE OF BURIAL: Aug 22 1914

20. UNDERTAKER: Rose — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of La Belle
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176.
(No. ..... , ... St.)

File No. 114
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John T. Morgan.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: Feb. 10. 1857
(Month) (Day) (Year)

7. AGE: 57 yrs. 10 mos. 21 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer.

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: John Morgan.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Ann E. Gillatt.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. Morgan.
(Address) Lorenz R.F.D. Ida.

15. Filed DEC 10 191 4 Ray Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 21 191 4
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Fell from load of potatoes. Broke neck
Instantly killed
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H. Fisher. M. D.
Nov 27 1914 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Little Butte Cem. DATE OF BURIAL: Nov. 24 191 4

20. UNDERTAKER: M. T. Peck ADDRESS: Rigby Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. .....
Registered No. 28
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Drewry T. Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Babe.

6. DATE OF BIRTH Oct. 6th 1914
(Month) (Day) (Year)

7. AGE ..... yrs. 1 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Babe.

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W. B. Campbell.

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Amy Turner.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Campbell.
(Address) Rigby I.

15. Filed Dec 10 1914 Ray St. Ficker.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 24 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1914; to Nov 24 1914
that I last saw him alive on Nov 21 1914
and that death occurred on the date stated above, at 2a M.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia

.....(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) A. M. Palmer
.....(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) [illegible] M. D.
Nov 25 1914 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Rigby. Ida. DATE OF BURIAL: Nov 25 1914

20. UNDERTAKER: Freeiss. ADDRESS: Rigby. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No.
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James C. Myler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Nov (Month) 20th (Day) 1914 (Year)

7. AGE ____ yrs. ____ mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Rigby, Idaho

10. NAME OF FATHER H. B. Myler

11. BIRTHPLACE OF FATHER (State or Country) Clarkston Utah.

12. MAIDEN NAME OF MOTHER May Ritter

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. B. Myler
(Address) Rigby, Idaho

15. Filed Dec 10 1915 Ray W. Fiske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from On Nov 26 1914, to Nov 26 1914, that I last saw him alive on Nov 26 1914, and that death occurred on the date stated above, at 11:40 P. M.

The CAUSE OF DEATH* was as follows:

Intussusception

(Duration) ____ yrs. ____ mos. one ds.

Contributory (Secondary) Infancy

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. A. Anderson M. D.

Nov 29 1914 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rigby Cemetery | DATE OF BURIAL Nov. 28 1914

20. UNDERTAKER W. J. Reed & Son | ADDRESS Rigby Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Le Bell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. .....
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira Lorde

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 5th (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry Lorde

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Leona Skelton

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Lorde
(Address) LaBelle, Ida

15. Filed Nov. 10 1914 Roy H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6th 1914, to Nov. 7th 1914, that I last saw him alive on Nov 7th 1914 and that death occurred on the date stated above, at 4. P. M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.
11/9 1914 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby, Ida — DATE OF BURIAL: Nov. 9th 1914

20. UNDERTAKER: M. J. Peck & Sons — ADDRESS: Rigby, Ida

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson Ashton
City of Annis
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 9471
Registered No. 32
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A. Cutler.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: 7
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Nov 23 (Month) (Day) 1870 (Year)

7. AGE: 73 yrs. 11 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: Mr Newman

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. H. Cutler.
(Address) Lorenzo R.F.D.

15. Filed Nov 10 1914 Ray H. Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. 25th. (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1914 to Oct 25th 1914 that I last saw her alive on Oct 25th 1914 and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Melton M. D.
Oct 25 1914 (Address) Menan, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Little Butte Cem | DATE OF BURIAL: Oct 27 1914

20. UNDERTAKER: Dinwoody | ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 94

Registered No. 54

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Jefferson
City of Menan (No. ..... St.)

Registration District No. 98
Primary Registration District No. 2116

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Grew.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Mar 6th (Month) (Day) 1834 (Year)

7. AGE: 80 yrs. 7 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry business or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Robt Grew.

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Fanny Greely

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS T[illegible] BEST OF MY KNOWLEDGE
(Informant) Oscar W. Grew
(Address) Menan Ida.

15. Filed Nov 10 1914 Ray S. Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 19 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1914, to Oct 19 1914, that I last saw him alive on Oct 19 1914 and that death occurred on the date stated above, at 2P M.

The CAUSE OF DEATH* was as follows:

Senility. Apoplexy.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Melton M. D.
Oct 20 1914 (Address) Menan Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Little Butte Cem. DATE OF BURIAL: Oct 21 1914

20. UNDERTAKER: Dunwoody. ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 124

County of Bingham

Primary Registration District No. 2007

City of Idaho

(No. Jonas Addition St.)

File No. 8472

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Hopkins

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

July (Month) 9 (Day) 1873 (Year)

7. AGE

41 yrs. 8 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Delivery man

(b) General nature of industry business, or establishment in which employed (or employer) Own Horse

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER David Hopkins

11. BIRTHPLACE OF FATHER (State or Country) South Wales

12. MAIDEN NAME OF MOTHER Thomas

13. BIRTHPLACE OF MOTHER (State or Country) South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Esker Eskelsen

(Address) Blackfoot

15. Filed Nov 6 1914 M. E. Fabrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1914, to Nov 1914, that I last saw him alive on Oct 20 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mytral Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H J Simmons M. D.

4/5 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cem Blackfoot — DATE OF BURIAL: Nov 6 1914

20. UNDERTAKER: Esker Eskelsen — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1067
(No. ..... St.)

File No. 9475
Registered No. 73
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Edward Leigh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	(Write the word) Married

6. DATE OF BIRTH
Jan (Month) 22 (Day) 1857 (Year)

7. AGE
63 yrs. 5 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) 0

9. BIRTHPLACE (State or Country) Salt Lake City, Salt Lake Co. Utah.

10. NAME OF FATHER Daniel H. Leigh

11. BIRTHPLACE OF FATHER (State or Country) Llanelly So. Wales

12. MAIDEN NAME OF MOTHER Celia Thorne

13. BIRTHPLACE OF MOTHER (State or Country) Llanelly So. Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lulu McAtee (Leigh)
(Address) Twin Falls Idaho

15.
Filed Nov. 18 1914 M. E. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov. (Month) 15th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 11 1914 to Nov 15 1914
that I last saw h alive on Nov 15 1914
and that death occurred on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:
Cancerous Liver and Stomach

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.
11/16 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gunderland Cemetery — DATE OF BURIAL: Nov 16 1914

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Insane Asylum St.)

File No. 914
Registered No. 74
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James R. Logan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Caucassian	Married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
60 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer): Groceries

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Margret Lowery

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. T. Boyle
(Address) Blackfoot, Idaho

15. Filed Nov. 18 1914 M. E. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15th 1914, to Nov 17 1914, that I last saw him alive on Nov. 17 1914, and that death occurred on the date stated above, at 11-0'clk M.

The CAUSE OF DEATH* was as follows:

Progressive Bulbar Paralysis

(Duration) Don't Know yrs. mos. ds.

Contributory (Secondary): Don't Know

(Duration) Don't Know yrs. mos. ds.

(Signed) Geo. T. Boyle M. D.

Nov 18 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos. 2 days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death? Don't Know

Former or usual residence: Ashton, Idaho

19. PLACE OF BURIAL OR REMOVAL: Lincoln Nebraska | DATE OF BURIAL ... 191...

20. UNDERTAKER: E.T.Peck | ADDRESS: Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 94
Registered No. 75

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot R.D. #1 (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Duckworth Lord

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 46 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James C Polande
(Address) Shelley Idaho Box 364

15. Filed Nov 19 1914 W C Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1914, to Nov 18 1914, that I last saw him alive on Nov 17 1914, and that death occured on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:
Cardiac insufficiency
Mitral stenosis with insufficiency
(Duration) 14 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism
(Duration 3 yrs. — mos. — ds.

(Signed) W.W. Beck M. D.
11/19 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley Idaho — DATE OF BURIAL: Nov 20 1914

20. UNDERTAKER: James C Polande — ADDRESS: Shelley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 94

Registered No. 76

1. PLACE OF DEATH.

Registration District No. 12

County of Bingham Primary Registration District No. 2164

City of Blackfoot (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ursula Allred

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November (Month) 26 (Day) 1854 (Year)

7. AGE: 59 Yrs. 11 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Samuel Mullener

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Richardson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fanny Adams.
(Address) Blackfoot, Idaho

15. Filed Nov. 21 1914 M. E. Parkin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1914, to Nov 19 1914, that I last saw her alive on Nov 19 1914, and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) ..... Yrs. 8 mos. — ds.

Contributory (Secondary) Rheumatism

Duration several years ago causing Mitral Stenosis

(Signed) W. W. Beck M. D.

11/20/1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside-Thomas — DATE OF BURIAL: Nov 22 1914

20. UNDERTAKER: Fanny Adams. — ADDRESS: Blackfoot.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)
File No. 114
Registered No. 77

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Neil McLean Sorensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 1 (Month) (Day) 1910 (Year)

7. AGE: 4 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Neil Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nellie Ida McLean

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gertrude Welch
(Address) Blackfoot, Idaho.

15. Filed Nov 27 1914 M. E. Price Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1914, to Nov 25 1914, that I last saw him alive on Nov 25 1914 and that death occured on the date stated above, at 3:00 A.M.
The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) — Yrs. — mos. 10 ds.
Contributory (Secondary) —
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. W. Beck M. D.
11/26 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rest Park — DATE OF BURIAL: Nov 24 1914

20. UNDERTAKER: E Peck — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 721
Primary Registration District No. 2194
(No. ..... St.)
File No. 1179
Registered No. 179

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Clarence Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Nov. (Day) 20 (Year) 1900

7. AGE ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Bingham Co. Idaho

10. NAME OF FATHER Robert E. Harris

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Hannah Mary Yates

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert E. Harris
(Address) Blackfoot Route 3

15. Filed Dec 1 1914 M. E. Yates Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Nov. (Day) 20 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27 1914, to Nov. 30 1914, that I last saw him alive on Nov. 29 1914, and that death occured on the date stated above, at 8:50 P.M.

The CAUSE OF DEATH* was as follows:

.....
.....
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Tuberculosis Left Arm.
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) M. E. Yates M. D.
12/1/1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: L. C. Cem. Blackfoot. DATE OF BURIAL: Dec 2 1914

20. UNDERTAKER: Robert E. Harris ADDRESS: Blackfoot

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 81
Primary Registration District No. 215E
File No. 19452
Registered No. 11

1. PLACE OF DEATH.
County of Bonner
City of Priest River (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Atterria Jackella

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	White	Single

6. DATE OF BIRTH: May (Month) 15th (Day) 1912 (Year)

7. AGE: 2 yrs. 6 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Jackella

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Josephina Mario

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jas. Branch
(Address) Priest River. Idaho

15.
Filed Nov 23 1914 E O McCauley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1914, to 23 1914 that I last saw h er alive on Nov 23 1914, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E O McCauley M. D.
Nov 23 1914 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River
DATE OF BURIAL: Nov 24 1914

20. UNDERTAKER: None
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ..... St.)

File No. 9183
Registered No. 99
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME E. V. Miller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Apr (Month) 26 (Day) 1 1857 (Year)

7. AGE: 57 yrs. mos. 6 ds. 9
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: William Miller

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Williams

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Bettie Miller
(Address) Gilbert Idaho

15. Filed Nov 1 1914 J. M. Finch Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to Oct 5 1914, that I last saw him alive on Oct 4 1914, and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:
Chronic Brights Disease
Valvular endocarditis
Stone right kidney-Cystic kidney.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. V. Honeywell M. D.
Oct 6 1914 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gilbert Ida — DATE OF BURIAL: Oct 8 1914

20. UNDERTAKER: W. C. Stoddard — ADDRESS: Gifford

BYNS - YORK CO., PTRS. & SONS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Clearwater

City of Orofino

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90

Primary Registration District No. 2168

(No. ....., ... St.)

File No. 94

Registered No. 45

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin F. Eastburne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 1849 (Month) 1 (Day) (Year)

7. AGE: 65 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. N. Groves
(Address) Orofino, Ida.

15. Filed Nov 1 1914 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. 8th. (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28th 1908 ~~9~~, to Oct. 8th 1914, that I last saw h~~im~~ alive on Oct. 8th 1914, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Chorea

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Insanity

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. N. Groves M. D.

Oct 21 1914 (Address) Per J. M. Davis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Asylum Cemetery, Orofino, Ida. | DATE OF BURIAL: Oct. 10 1914

20. UNDERTAKER: Clarence R. Hill | ADDRESS: Orofino, Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 94
Registered No. 46

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Olof J. Pearson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
(Month) 1883 (Day) 1 (Year)

7. AGE
31 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. G. P. Shoestrom
(Address) Troy Idaho

15. Filed Nov 1 1914 J. M. Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
(Month) October (Day) 9th. (Year) 1914

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3rd 1913, to Oct. 9th 1914, that I last saw h. s.m. alive on Oct. 9th 1914, and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:
Epilepsy -
(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Insanity
(Duration) 1 yrs. 2 mos. ds.

(Signed) John Livingus M. D.
Oct 9 1914 (Address) Orofino. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. mos. 6 days. In the State 23 yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence Genesee, Ida.

19. PLACE OF BURIAL OR REMOVAL Troy Ida | DATE OF BURIAL Oct 11 1914

20. UNDERTAKER W. C. Shaw | ADDRESS Giffords

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2108
City of Orofino (No. ....., ... St.)
File No. 94
Registered No. 47
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stuart Cunningham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Aug (Month) 1 (Day) 1840 (Year)

7. AGE: 74 yrs. 3 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Atkins
(Address) Orofino Ida

15. Filed Nov 1 1914 J. McDaniel Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1914, to Nov 4 1914, that I last saw him alive on Oct 8 1914, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) — yrs. mos. ds.

Contributory (Secondary) Valvular Heart Disease

(Duration) — yrs. mos. ds.

(Signed) J. McDaniel M. D.

Nov 1 1914 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino	Nov 5 1914

20. UNDERTAKER	ADDRESS
W. C. Hodnett	Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock
City of Soda Springs (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048

File No. 94
Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glen Philip Shoemaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. July 21 1914
(Month) (Day) (Year)

7. AGE — Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Theodore Shoemaker

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Ellen Ellis

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Theodore Shoemaker
(Address) Dawson Ida

15. Filed Nov 10, 1914 Eva Kasee Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 23 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1914, to Oct 25 1914, that I last saw h[illegible] alive on Oct 23 1914 and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Chron Indigestion & Fermentation post mortem
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Sunlight Sleep
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Eva Kasee M. D.
Nov 10 1914 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Centralia Kansas — DATE OF BURIAL Oct 28 1914

20. UNDERTAKER Crawford and Schumacher — ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of [redacted]
BOARD OF [redacted]
Bureau of Vital [redacted]

File No. 9458
Registered No. 43

1. PLACE OF DEATH.
County of Bannock
City of McCammon (No. ..... St.)
Registration District No. 11
Primary Registration District No. 2647
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catharine Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Nov (Month) 25th (Day) 1838 (Year)

7. AGE: 75 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Thomas Flaulley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget McQue

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mary A Lane
(Address): McCammon Idaho

15.
Filed Nov 10, 1914 Eli Kaney Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/28 — 1914, to 10/29 — 1914, that I last saw h[er] alive on 10/28 — 1914, and that death occured on the date stated above, at 5-35 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 10 — ds.

Contributory (Secondary) —

— (Duration —) yrs. ..... mos. — ds.

(Signed) G M Cooper M. D.

19..... (Address) McCammon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon — DATE OF BURIAL: Oct 31 1914

20. UNDERTAKER: O. A. Schumacher — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 9488

Name Catherine Scott

Date of Death 10-29-14

Cause of Death Broncho-pneumonia

Contributary Cause of death

(Sign here) L. H. Cooper M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Heyburn
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18
Primary Registration District No. 2102
(No. ....., ... St.)

File No. 4
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Amand Newton.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 24 (Day) 1880 (Year)

7. AGE: 34 yrs. 3 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Harry Rodgers.

11. BIRTHPLACE OF FATHER (State or Country): Ill. — Chicago

12. MAIDEN NAME OF MOTHER: Amanda Barlow

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake Co. Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm H Newton
(Address) Pocatello Idaho

15.
Filed Nov. 10 1914 V R Killeen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 6 1914, to Oct. 7 1914, that I last saw her alive on Oct. 6. 1914 and that death occurred on the date stated above, at 19. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Diabetes Mellitus
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. R. Killeen M. D.
19 (Address) Heyburn Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Heyburn Ida — DATE OF BURIAL: Oct 8 1914

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Minidoka
City of Heyburn
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18
Primary Registration District No. 2102
(No. ..... , ... St.)

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John D. Griffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Oct. (Month) 2 (Day) 1862 (Year)

7. AGE: 52 yrs. ..... mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Howard Co Iowa.

10. NAME OF FATHER: Patrick Griffin.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Katie Dardis.

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno Peter Breen
(Address) Butte Mont.

15.
Filed Nov 10 1914 V. P. Killen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 19 1914, to Oct. 25 1914, that I last saw him alive on Oct. 24 1914, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Tuberculosis (?)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Killen M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greco Iowa
DATE OF BURIAL: about Nov. 1st 1914

20. UNDERTAKER: L. B. Geelogy
ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1084
(No. ....., ... St.)

File No. 0[illegible]
Registered No. 213

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Boise
City of Idaho City
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Garrett Warner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 16 (Day) 1891 (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho City

10. NAME OF FATHER: Wm Warner.

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Clara Warner

13. BIRTHPLACE OF MOTHER (State or Country): Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Warner
(Address) Idaho City

15. Filed 9-3 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 1st (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1914, to Aug 31 1914, that I last saw him alive on Aug 1 1914, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Lobar)
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Dr Toomey M. D.
9/2 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/4 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRUS - YORK CO., PTRS. & BDRS. 24658

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 9491

Name Garrett Warner

Date of Death 8-1-14

Cause of Death Lobar Pneumonia

Contributary Cause of death ←

(Sign here) C. B Toney M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 1 9492
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Lyons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1890 (Year)

7. AGE: 23 yrs. 11 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Salem Ida

10. NAME OF FATHER: James Andrews

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alice Montgomery

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles E Wright
(Address) St Anthony

15. Filed Jan 9th 1914 W D West Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1914, to Dec 30 1914, that I last saw her alive on Dec 30 1914 and that death occurred on the date stated above, at 10 34 A.M.

The CAUSE OF DEATH* was as follows:
Cardiac insufficiency

(Duration) ..... yrs. ..... mos. ½ hour ds.
Contributory (Secondary) Abscess appendicitis
Rheumatism from infancy
(Duration) ..... yrs. 14 mos. ..... ds.

(Signed) A Merrifield M. D.
Jan 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milford
DATE OF BURIAL: Jan 2 1914

20. UNDERTAKER: Howe
ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STYLE YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2077
File No. [redacted]
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Ashcraft

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
Nov (Month) 27 (Day) 1914 (Year)

7. AGE
yrs. 1 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) St Anthony Ida

10. NAME OF FATHER Jacob Ashcraft

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Cora Wilkinson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Moorfield
(Address) St Anthony

15. Filed Jan 9th 1915 WD Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1914, to Dec 28 1914, that I last saw her alive on Dec 28 1914, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Capillary Bronchitis

(Duration) yrs. mos. 1/2 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A Moorfield M. D.
Dec 29 1914 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Teton Ida	Dec 28 1914

20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [redacted]
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Egin
Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clyde Morris

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Egin Ida

10. NAME OF FATHER: Edward Morris

11. BIRTHPLACE OF FATHER: Utah (State or Country)

12. MAIDEN NAME OF MOTHER: Nettie Orgill

13. BIRTHPLACE OF MOTHER: Utah (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Morris
(Address) Paradise Utah

15. Filed Dec 3d 1914 W Dewey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 2d (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at NW 19[illegible] to ..... 191....
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows: The Midwife says she was a "Blue" Baby

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W Dewey M. D.
..... 19..... (Address) Local Agent

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Egin Ida DATE OF BURIAL: Dec 3d 191[illegible]

20. UNDERTAKER: none ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 9495
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): St Anthony

10. NAME OF FATHER: J. F. Miller

11. BIRTHPLACE OF FATHER (State or Country): Providence Utah

12. MAIDEN NAME OF MOTHER: Ellen Lowe

13. BIRTHPLACE OF MOTHER (State or Country): Providence Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D R Douglass
(Address) .....

15. Filed Jan 9th 1915 W O Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1914, to Dec 25 1914, that I last saw her alive on Dec 24 1914 and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:
Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Malaria
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) A Merrifield M. D.
Dec 27 1914 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton Ida — DATE OF BURIAL: Dec 27 1914

20. UNDERTAKER: None — ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

County of Madison

Primary Registration District No. 2177

City of Teton

(No. ....., ... St.)

File No. [illegible] 96

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sivard Samuel Hutchens

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	Single

6. DATE OF BIRTH: Nov (Month) 26 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Teton Idaho

10. NAME OF FATHER: Sivard Hutchens

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edna Stock

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sivard Hutchens
(Address) Teton

15. Filed Jan 9th 1915 — W D Weeks — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1914, to Dec 11 1914, that I last saw him alive on Dec 8 1914, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Mossfield M. D.

Dec 1914 (Address) Teton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton Cemetery — DATE OF BURIAL: Dec 12 1914

20. UNDERTAKER: None — ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

File No. 1497

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Hensel McCarthur

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov (Month) 6 (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Co Fremont

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Edith McCarthur

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Hn McCarthur

(Address) St Anthony

15. Filed Aug 9th 1915 W. T. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191.., to — 191.., that I last saw h in alive on Nov 16 191.., and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:

Cupelary Bronchitis

(Duration) ..... yrs. ..... mos. 24 hrs

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Morfield M. D.

Dec 19 14 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nelson Cemetery — DATE OF BURIAL ..... 191..

20. UNDERTAKER None — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

YMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 99

County of Fremont

Primary Registration District No. 2177

City of St Anthony (No. ....., ... St.)

File No. 9498

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rasmus Christianson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Sept (Month) 23rd (Day) 1829 (Year)

7. AGE: 85 yrs. 1 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Christian Christianson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Nels Rasmussen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha Hammond
(Address) St Anthony Idaho

15. Filed Dec 9th 1914 W Beers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at no time 191.., to ..... 191..., ~~that I last saw h... alive on ..... 191...~~, and that ~~death~~ occurred on the date stated above, at ..a.. M.

The CAUSE OF DEATH* was as follows: He was dead when I called to see him from who I could learn he died of Lagrippe

(Duration) 8 yrs. ..... mos. two ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. Weeks M. D.

Dec 6 1914 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hooper Utah	Dec 10 1914
20. UNDERTAKER	**ADDRESS**
W. D. Mayer	St Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2178

File No. [redacted] 9490

County of Madison

City of Moody (Locality), (St.)

Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lona Ashcraft

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: June (Month) 26 (Day) 1913 (Year)

7. AGE: 1 yrs. 5 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER Jacob C. Ashcraft

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Ruby Karren

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Jacob C Ashcraft

15. Filed 12-5 1914 G E Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 12 (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [redacted] 191..., to [redacted] 191..., that I last saw h[redacted] alive on 12-4 1914, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Stumpf, M. D.

19 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Yetone — DATE OF BURIAL: 12/6 1914

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-35 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 9508
Registered No. 70

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reid G Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH. October 26 1914
(Month) (Day) (Year)

7. AGE: ..... Yrs. 1 Mos. 1½ Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Sugar

10. NAME OF FATHER: Robert H. Hamilton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ada Gmelson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J H Hamilton
(Address) Sugar

15. Filed 12-14 1914
G L Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1914, to Dec 9 1914, that I last saw him alive on Dec 9 1914, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia.

(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ryburn
DATE OF BURIAL: 12/11 1914

20. UNDERTAKER
ADDRESS Ryburn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Fremont Primary Registration District No. 2178
City of Sugar (No. ....., ... St.) File No. [redacted]
If death occurs away from usual residence, give facts called for under special information. Registered No. 21
2. FULL NAME Rachel Evans
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: March (Month) 18 (Day) 1900 (Year)

7. AGE: 6 yrs. 9 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Fremont Co. Ida.

10. NAME OF FATHER: Edward L. Evans

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alice L. Partington

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward L Evans
(Address) Sugar City

15.
Filed 12-14 1914 G. L. Locke
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw her alive on 12-14 1914,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Spinal Meningitis

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A. Shupe M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 12/16 1914

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 9502
Registered No. 72

1. PLACE OF DEATH.
County of Madison
City of Rigby
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Ellsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Bale

6. DATE OF BIRTH. Oct (Month) 28 (Day) 1914 (Year)

7. AGE ....Yrs. 1 Mos. 30 Ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Bale
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Rigby

10. NAME OF FATHER Jerome Ellsworth

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Klingler

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. Ellsworth
(Address) Rigby

15. Filed 12-24 1914 [illegible] Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....1914...., to ....1914....,
that I last saw h.....alive on .....1914.....,
and that death occured on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Pneumonia ?

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration .....yrs.....mos.....ds.
(Signed) none M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: 12/24 1914

20. UNDERTAKER: Rigby Mortuary
ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. [illegible]
Registered No. 73
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Infant

6. DATE OF BIRTH
12 (Month) 23 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER John Wyatt

11. BIRTHPLACE OF FATHER (State or Country) Wt

12. MAIDEN NAME OF MOTHER Martha Montgomery

13. BIRTHPLACE OF MOTHER (State or Country) Wt

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Wyatt
(Address) .....

15.
Filed 12-26 1914 GLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
12 (Month) [illegible] (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Premature
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) GL Teape M. D.
..... 19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton
DATE OF BURIAL: 12-28 1914

20. UNDERTAKER: none
ADDRESS: 2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9504
Registered No. 74

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 2178
(No. ....., ... St.)

2. FULL NAME Kenneth R. Woodruff

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec. (Month) 28 (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 2 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Arthur N. Woodruff

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Mary Ricks

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur N. Woodruff
(Address) Rexburg

15.
Filed 12-29 1914
G. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 28, (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1914, to Dec. 28, 1914, that I last saw h[illegible] alive on Dec. 28, 1914, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Acute Broncho pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Cannon M. D.
Dec. 29 1914 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 12/30/1914

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Howe, Idaho
(No. ....., ... St.)

Registration District No. 59
Primary Registration District No. 2139

File No. 120
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John William Kyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: August (Month) 4th. (Day) 1847 (Year)

7. AGE: 67 yrs. 4 mos. ~~Four~~ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranching
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Whitewater Wis.

10. NAME OF FATHER: William Kyle

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Elizabeth Dixon

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. W. Kyle
(Address) Howe Idaho

15.
Filed Dec. 10th. 1914 E. W. Fox
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1915 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191...
that I last saw h... alive on ~ 191...,
and that death occurred on the date stated above, at ~ M.

The CAUSE OF DEATH* was as follows:
Chronic heart disease
Myocarditis
.....
..... (Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) .....
..... (Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Howe, Idaho — DATE OF BURIAL: Dec 12 1915

20. UNDERTAKER: Chas Kyle — ADDRESS: Howe, Idaho

CIANS should state CAUSE OF DEATH in plain terms, Exact statement of OCCUPATION is very important. See instructions. of certificate.

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Idaho
County of Shoshone — Registration District No. 103
City of Wallace — Primary Registration District No. 1001
(No. ....., ... St.)
File No. [illegible]
Registered No. 51
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Francis Kabat

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 13th (Day) 1914 (Year)

7. AGE: 44 yrs. 4 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J D Kabat

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: did not Know

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Kabat
(Address): Wallace

15.
Filed Dec 31 1914 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1914, to Dec 13 1914, that I last saw her alive on Dec 13 1914 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) No regular medical yrs. mos. ds.
Contributory attendance no duration
(Secondary) unknown to me
(Duration) yrs. mos. ds.

(Signed) C V. Dunn M. D.
Dec 15 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Dec 15 1914

20. UNDERTAKER: W E Graham — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 10760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 9508
Registered No. 50

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Merle Whitney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: November (Month) 27 (Day) 1914 (Year)

7. AGE: 0 yrs. 0 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Grangeville. Idaho

10. NAME OF FATHER: Merle A. Whitney

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Delia Pendel

13. BIRTHPLACE OF MOTHER (State or Country): Grangeville Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. A. Whitney
(Address) Grangeville

15. Filed Dec 31 1914 G S Hancock Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 — 1914, to Dec 12 — 1914, that I last saw her alive on Dec 12 1914, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

— (Duration) — yrs. — mos. — ds.

Contributory (Secondary) Debility

— (Duration) — yrs. — mos. — ds.

(Signed) W. H. Warner M. D.

12-13-1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Dec 14 1914

20. UNDERTAKER: G S Hancock — ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181

File No. .....
Registered No. 49
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis E Arnold

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH
Oct. (Month) 23 (Day) 1848 (Year)

7. AGE
65 yrs. 1 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Michigan Saginaw Co.

10. NAME OF FATHER ~~Gideon~~ Arnold

11. BIRTHPLACE OF FATHER (State or Country) York State

12. MAIDEN NAME OF MOTHER Mary Ann Spalding

13. BIRTHPLACE OF MOTHER (State or Country) York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G H Arnold
(Address) Grangeville Ida

15.
Filed Dec 31 1914 G B Bluethen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1914 to Dec 3 1914
that I last saw h.m alive on Nov 16 1914
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Valvular lesion of heart
.....
.....
(Duration) Don't Know yrs. ..... mos. ..... ds.
Contributory Arteriosclerosis
(Secondary)
(Duration) Don't Know yrs. ..... mos. ..... ds.
(Signed) G B Bluethen M. D.
Dec 4 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Prairie View	Dec 6 1914

20. UNDERTAKER	ADDRESS
E S Hancock	Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOPS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. [illegible]
Registered No. 48

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Williams Von Berge

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: March 16 1842 (Month) (Day) (Year)

7. AGE: 72 yrs. 6 mos. 16 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Frederick Von Berg

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elsa Magdelena Rudebort

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil H. Von Berge
(Address) Grangeville Ida

15.
Filed Dec 31 1914 G S Sloctlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 1 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914 to Dec 1 1914 that I last saw him alive on Dec 1 1914 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Sloctlin M. D.
Dec 2 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Dec 5 1914

20. UNDERTAKER: W E Graham
ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. [illegible]
Registered No. 48

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Homolka

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed
6. DATE OF BIRTH: June (Month) 24 (Day) 1834 (Year)
7. AGE: 80 yrs. 5 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Austria
10. NAME OF FATHER: John Homolka
11. BIRTHPLACE OF FATHER (State or Country): Austria
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (State or Country): Austria
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Homolka.
(Address) Grangeville Ida
15.
Filed Dec 31 1914 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 1 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1914 to Dec 1 1914 that I last saw h— alive on Nov 28 1914 and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Arterio-Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G S Stockton M. D.
12/3 1914 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash
DATE OF BURIAL ..... 191...
20. UNDERTAKER: W E Graham
ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
File No. 2512
Registered No. 96

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Duallwood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
(Month) (Day) 1858 (Year)

7. AGE
56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER Jesse Duallwood

11. BIRTHPLACE OF FATHER
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Everett Smallwood
(Address) Burke Ida

15.
Filed Dec 26 1914
F. Leo Lumley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 26 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1914, to Dec 26 1914, that I last saw h-m alive on Dec 25 1914, and that death occured on the date stated above, at 3.30 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) D. D. Mowery M. D.
Dec 26 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: 12-27 1914

20. UNDERTAKER: Bruce & Webster
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1911
File No. 1914
Registered No. 94

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Wallace Hospital)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. B. Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	widower

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER W. Williams

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. D. Mowry
(Address) Kellogg Ida

15. Filed Dec 22 1914 F. Leo Dunlap Local Registrar

SYMS - YORK CO., PTRS. & SOES. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1914, to Dec 22 1914, that I last saw h[illegible] alive on Dec 21 1914 and that death occured on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tubercu-
losis
(Duration) Several mos. ds.
Contributory (Secondary) Alcoholism
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. D. Mowry M. D.
12/22 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kellogg Ida. DATE OF BURIAL Dec 23 1914

20. UNDERTAKER A. L. Wortley ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 9516
Registered No. 97

1. PLACE OF DEATH
County of Shoshone
City of County
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Wing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	not known

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 48 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Logger
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) not known

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D J Mowery
(Address) Wallace Ida

15. Filed 12/22 1914 F. Leo Dempsey Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 15 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1914, to Dec 15 1914, that I last saw him alive on Dec 14 1914 and that death occured on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage Meningitis
(Duration) Yrs. mos. 5 6 ds.
Contributory (Secondary) Exposure
(Duration) yrs. mos. ds.
(Signed) D J Mowery M. D.
12/22 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho. DATE OF BURIAL Dec 22 1914

20. UNDERTAKER B G Monteith ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of County
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 1913
Registered No. 91

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Hardena Louisa Slaughter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1860 (Year)

7. AGE: 54 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: D.W. Anderson

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Sarah Caulk

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C.V. Rankin
(Address) Seattle Wash.

15. Filed Dec 18, 1914 F. Leo Smiley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to Dec 17 1914, that I last saw her alive on Dec 16 1914, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation of heart
Chronic interstitial nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D.P. Mowry M. D.
Dec 18 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Dec 19 1914

20. UNDERTAKER: E.L. Moretti
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1,018

Registered No. 90

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 10 11

2. FULL NAME Vernon Vincent Hobbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Single

6. DATE OF BIRTH: July (Month) 16 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Idaho

10. NAME OF FATHER: M. P. Hobbs

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Leona P Wagner

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M P Hobbs
(Address) Wallace Ida

15. Filed Dec 16 1914 F. Leo Dempsey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1914, to Dec 16 1914, that I last saw h alive on Dec 16 1914, and that death occurred on the date stated above, at 7 00 a M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(Duration) ..... yrs. ..... mos. 6 8 hrs.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D R Mowry M. D.
12/17 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho | DATE OF BURIAL: Dec 17 1914

20. UNDERTAKER: Bruce G Morton | ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 1019
Registered No. 89

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dan Hagstrom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
60 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. Leo Lundy
(Address) Wallace Ida

15.
Filed Dec 14 1914 F. Leo Lundy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 12 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1914, to Dec 12 1914, that I last saw him alive on Dec 12 1914, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. Leo Lundy M. D.
Dec 14 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: 12/15 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 5 1320
Registered No. 88

1. PLACE OF DEATH
County of Shoshone
City of Wallace (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abraham Stolet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word.) married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 68 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Surrender

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Augger Stolt
(Address) Wallace Ida

15. Filed Dec 14 1914 F. Leo Dunfey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1914, to Dec 13 1914, that I last saw h alive on Dec 12 1914, and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:
Cardiac Dilatation
Chronic Nephritis
(Duration) 1 yrs. mos. ds.
Contributory (Secondary) Exposure & Old Age
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D R Mowry M. D.
12/14 1914 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Dec 16 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. C 9521

Registered No. 87

1. PLACE OF DEATH.

County of

City of

(No. , St.)

Registration District No. 70

Primary Registration District No. 81

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Gus Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 40 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Swanson

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Ida Jackson

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Miller
(Address): Missoula, Mont

15. Filed Dec 6 1914 F. Leo Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1914, to Dec 4 1914, that I last saw him alive on Dec 3 1914, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Gas Traumatic gangrene
infection of leg

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Injury Lt. left leg.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Mowery M. D.

12-4 1914 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Missoula Mont — DATE OF BURIAL: 12/7 1914

20. UNDERTAKER: Merle C. Thornber — ADDRESS: Kellogg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. County of Shoshone City of Wallace (If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 70
Primary Registration District No. 6011 (No. Canyon Creek Creek Dairy)

File No. 1942
Registered No. 86

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James Allen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: ..... 1 (Month) (Day) (Year)
7. AGE: 31 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
   (a) Trade, profession or particular kind of work: Miner
   (b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Nevada
10. NAME OF FATHER: James Allen
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: not Known
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
    (Informant) P A Allen
    (Address) Butte Mont
15. Filed Dec 5 1914 F. Leo Trinder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ——— 191—, to ——— 191—
    that I last saw h— alive on ——— 191—
    and that death occurred on the date stated above, at 5 30 P. M.
    The CAUSE OF DEATH* was as follows:
    Accidentally struck by M. K. Train
    ..... (Duration) ..... yrs. Instant mos. ..... ds.
    Contributory (Secondary)
    ..... (Duration) ..... yrs. ..... mos. ..... ds.
    (Signed) D. D. McCarty M. D.
    Nov 25 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
    At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
    Where was disease contracted, if not at place of death?
    Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Park City Utah — DATE OF BURIAL: Dec 6 1914
20. UNDERTAKER: Bruce & Worstell — ADDRESS: Wallace

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9523

Registered No. 85

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital St.)

2. FULL NAME John Krebs

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
52 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ethel L. Grubbs
(Address) Wallace Ida

15.
Filed Dec 7 1914
F. Leo Dunphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 27 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Nov 27 1914, that I last saw him alive on Nov 27 1914, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows: Tuberculosis Nephritis

(Duration) yrs. 2 mos. ds.
Contributory (Secondary) Arteriosclerosis
(Duration) yrs. mos. ds.

(Signed) D. L. Woodruff M. D.
Dec 2 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: Dec 3 1914

20. UNDERTAKER: D. G. Worstell
ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [illegible]
Registered No. 2

1. PLACE OF DEATH.
County of Bannock
City of Perry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048
(No. ....., ... St.)

2. FULL NAME Arial Tanner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.):

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 21 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Perry Idaho

10. NAME OF FATHER: John Alma Tanner

11. BIRTHPLACE OF FATHER (State or Country): Juella Utah

12. MAIDEN NAME OF MOTHER: Polly Delila Warner

13. BIRTHPLACE OF MOTHER (State or Country): Benjamin Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary J. Longgreen
(Address) Fr Laburetan Idaho

15.
Filed Jan 10, 1915 — Chas Kinney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Apparently Lives complaint of Mother Causing Childs death
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Perry Idaho
DATE OF BURIAL: April 10 1914

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4526
Registered No. 3

1. PLACE OF DEATH. Registration District No. 11
County of Bannock. Primary Registration District No. 2048
City of Treasureton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jennie Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Girl	White	

6. DATE OF BIRTH: Aug (Month) 14 (Day) 1912 (Year)

7. AGE: 2 yrs. 3 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Treasureton Idaho

10. NAME OF FATHER John Reader Reeder

11. BIRTHPLACE OF FATHER (State or Country) Wellsville Utah

12. MAIDEN NAME OF MOTHER Emilie Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Treasureton Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Landgreen
(Address) Treasureton Ida

15. Filed Jan 10 191 15 Eli Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Had a severe cold for 12 hours and died without a struggle

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Treasureton Idaho	Dec 15 1914
20. UNDERTAKER	ADDRESS
None	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [illegible]
Registered No. 4

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048
(No. ....., ... St.)

2. FULL NAME —

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: Dec 14 1914 (Month) (Day) (Year)

7. AGE: ... yrs. ... mos. ... ds. IF LESS than 1 day how many F hrs. or 10 min.

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country): Nampa

10. NAME OF FATHER: Charles Eli Harris

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ada Rodgers Nampa

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lundgren
(Address) Franklin

15.
Filed Jan 10 1915 Ella Kinney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 14 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1914, to Dec 19 1914 that I last saw h[illegible] alive on Dec 14 1914, and that death occurred on the date stated above, at 11:10 A M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Mrs Mary Lundgren M. D.
Dec 14 1914 (Address) Franklin

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: Dec 14 1914

20. UNDERTAKER: Nurse — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Fractions of YEARS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9530

Registration District No. 39.
Primary Registration District No. 2087
(No. ..... St.)
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Burke.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Arthur King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 4 (Day) 1862 (Year)

7. AGE: 52 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or emp[illegible]):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Wiley King

11. BIRTHPLACE OF FATHER (State or Country): U.S.A.

12. MAIDEN NAME OF MOTHER: Eliza Ann Evans.

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Seward D. King
(Address) Burke Ida

15. Filed 12-7 1914
J. Thurston
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/1, 1914, to 12/7, 1914, that I last saw him alive on 12/4/, 1914, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Pike M. D.
12/7/1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke Ida
DATE OF BURIAL: Dec 8 1914

20. UNDERTAKER: A B Evans
ADDRESS: Burke

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 9531
Registered No. 38

1. PLACE OF DEATH.
County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Sept. (Month) 12 (Day) 1856 (Year)

7. AGE
57 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Seder City, Utah

10. NAME OF FATHER
Joseph Walker

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER
Bettie Smith

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Richard. Lewis
(Address) Malad, Idaho

15.
Filed 7-6 1914
D C Ray
Local Registrar

SVMS - YORK CO., PTRS. & SOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1914, to July 2 1914, that I last saw h er alive on July 2 1914, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
Contributory Pleurisy
(Duration) Yrs. 1 mos. 10 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
7-7 1914 (Address) D C Ray

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: July 7 1914
20. UNDERTAKER: D. S. Johnson — ADDRESS: Malad

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1.1.32

Registered No. 21

1. PLACE OF DEATH.

County of Oneida

City of Woodruff

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H. Heaton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH. Jan (Month) 13 (Day) 1871 (Year)

7. AGE: 43 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah, Box Elder Co.

10. NAME OF FATHER: John Heaton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jenette Sinclair

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. J. Howell

(Address) Woodruff, Oneida Co. Idaho

15. Filed 7-21 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Killed by being hit by
engine for D. & R. G.
Accidental

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) T. J. Howell Coroner M. D.

7-21 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portage Utah — DATE OF BURIAL: July 22 1914

20. UNDERTAKER: W. E. Johnson — ADDRESS: Malad Ida

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 1111
Registered No. 22

1. PLACE OF DEATH.
County of Oneyda
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph J. Lusk
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 24 (Day) 1875 (Year)

7. AGE: 39 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad, Ida.

10. NAME OF FATHER: John W. Lusk

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Martha Tidwell

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R E Jones
(Address) Malad City Ida

15. Filed July 30 1914
D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1914, to July 1914, that I last saw h alive on 7-22 1914 and that death occured on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuber
Chronic

(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) D C Ray M. D.
7-30 1914 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Aug 1 1914
20. UNDERTAKER: D.S. Johnson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVISS - YORK CO., PTRS. & STRS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ammon
City of Arbon

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. [illegible]
Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Katharine Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 5 (Month) 13 (Day) 1912 (Year)

7. AGE: 2 yrs. 3 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: [illegible]
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ammon Co Idaho

10. NAME OF FATHER: Emmett O. Lee

11. BIRTHPLACE OF FATHER (State or Country): Washington State

12. MAIDEN NAME OF MOTHER: Katharine Stott

13. BIRTHPLACE OF MOTHER (State or Country): Washington State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev. Thos. D. Lee
(Address) Arbon Idaho

15. Filed 8/26 1914 W. C. Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/17 1914, to 8/26 1914 that I last saw h[illegible] alive on 8/20 1914 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
General Emaciation, resulting into Meningitis.

..... (Duration) ..... yrs. 1 mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Thomas M. D.
8/26 1914 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cemetary Arbon Ida. DATE OF BURIAL: Aug 27 1914

20. UNDERTAKER: none ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Katharine Lee

now lying buried in Arbon Cemetery, in the City or Town of Arbon

County of Oneida State of Idaho, who died on the 26 day of August, 1914, Aged ____ years ____ months

____ days, the cause of death being General Emaciation and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

J. M. Kerns, M.D. attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Freeze Cemetery in the City or Town of Potlatch - rural County of Latah

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Oneida it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 6th day of July, A.D. 1977.

Permit issued to:
Jack Henderson
Henderson Funeral Home
P. O. Box 4667
Pocatello, Idaho 83201

Janet M. Wick
by _____ Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of _____ State of Idaho, this _____ day of _____, 19__.

_____
Health Officer

FORM BH 56-018

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

County of Oneida.

City of Malad. (No. ....., ... St.)

File No. 1.0.32

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilfred Fredricksen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... 1 ..... (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Brigham Utah.

10. NAME OF FATHER James C. Fredricksen.

11. BIRTHPLACE OF FATHER (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER Hanah Neilsen.

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James C. Fredricksen

(Address) Brigham City Utah

15. Filed 9-28 1914 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 27, 1914. ..... 191 ..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1914, to Aug 27 1914, that I last saw h[illegible] alive on Aug 27 1914 and that death occured on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows:

Accidental by
Hay derrick falling &
Crushing Skull

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs ..... mos. ..... ds.

(Signed) D C Ray M. D.

8/27 1914 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Brigham City Utah.

DATE OF BURIAL: Aug. 29 1914

20. UNDERTAKER: P E Johnson

ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9537
Registered No. 76

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ... St.)

Registration District No. 76
Primary Registration District No. 2069

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse James Kent

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: August 9th (Month) (Day) 1914 (Year)
7. AGE: ..... yrs. ..... mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Malad Ida
10. NAME OF FATHER: Jesse Kent
11. BIRTHPLACE OF FATHER (State or Country): Malad Idaho
12. MAIDEN NAME OF MOTHER: Flassie Wilson
13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jess James Kent
(Address) Malad Ida
15. Filed 9-3 1914 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September 2nd (Month) (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1914, to Sept 2 1914
that I last saw him alive on Sept 2 1914
and that death occurred on the date stated above, at 1920 P. M.
The CAUSE OF DEATH* was as follows:
Acute Bronchitis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D C Ray M. D.
9/3 1914 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [illegible] Ida — DATE OF BURIAL: 9-4 1914
20. UNDERTAKER: D E Johnson — ADDRESS: Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. All blanks should be filled.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9538

Registered No. 27

PLACE OF DEATH.

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Jones Sr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct. (Month) 4 (Day) 1824 (Year)

7. AGE: 89 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Sailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Joseph Jones

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Grunland

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles A. Jones
(Address) North Ogden, Utah

15. Filed 9-25 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1914, to Sept 24 1914, that I last saw him alive on Sept 24 1914 and that death occured on the date stated above, at 4 00 M.

The CAUSE OF DEATH* was as follows:

Pleurisy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Allen M. D.

9/26 1914 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: North Ogden Ut. DATE OF BURIAL: Sept. 28 1914

20. UNDERTAKER: Stohl Furn Co. ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [illegible]
Registered No. 28

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2069
City of Malad (No. ....., ... St.)
Samaria

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Roderick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many 8 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry business or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Roderick

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ethel Johns

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Roderick
(Address) Samaria Malad Idaho

15.
Filed 10-3 1914 D G Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1914 to ..... 191..
that I last saw h[illegible] alive on Oct 3 1914
and that death occurred on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Insanition

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D G Ray M. D.
..... 19..... (Address) Malad City Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria Ida
DATE OF BURIAL: Oct 3 1914

20. UNDERTAKER: None
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. L 9540
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Selma Thoroughman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH
Oct (Month) 3 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad Idaho

10. NAME OF FATHER Harvey Thoroughman

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Mabel Sleeper

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey Thoroughman
(Address) Malad City Ida

15.
Filed Oct 11 1914 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1914, to ..... 191..., that I last saw her alive on Oct 10 1914 and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:
Premature birth

..... (Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
10/11 1914 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida	10-11 1914

20. UNDERTAKER	ADDRESS
D E Johnson	Malad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ..... , ... St.)

Registration District No. 76
Primary Registration District No. 2069

File No. 1914
Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 30 mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Malad Ida

10. NAME OF FATHER: Harry Brown

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Pearl Duncan

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Brown
(Address) Malad R F D Ida

15.
Filed Oct 16 1914 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1914, to ..... 191..., that I last saw h[illegible] alive on Oct 15 1914 and that death occurred on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
10/15/1914 (Address) Malad City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: home place Oneida County Idaho
DATE OF BURIAL: Oct 15 1914

20. UNDERTAKER: None
ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

File No. 1142
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Oneida
City of Malad

2. FULL NAME David P. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. Not Known (Month) 1 (Day) (Year)
7. AGE: 78 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country) Wales
10. NAME OF FATHER Morgan Jones
11. BIRTHPLACE OF FATHER (State or Country) Wales
12. MAIDEN NAME OF MOTHER Bettsie Jones
13. BIRTHPLACE OF MOTHER (State or Country) Wales
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John D. Williams
(Address) Malad Idaho
15. Filed 10-29 1914 — L. Ray — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Probably apoplexy found dead in home. Natural causes
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) D. C. Ray M. D.
10-29 1914 (Address) Malad City, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cherry Creek Ida — DATE OF BURIAL: Oct 28 1914
20. UNDERTAKER: Stohl Furn. Co — ADDRESS: Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9543
Registered No. 2

1. PLACE OF DEATH.
County of Oneida
City of Idaho (Malad)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Matilda Lusk Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: July 13, 1861 (Month) (Day) (Year)

7. AGE: 53 yrs. 3 mos. 20 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah, U.S.A.

10. NAME OF FATHER: John W. Lusk

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Ester O. Park

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee, U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. R. Evans
(Address) Malad, Idaho.

15. Filed 11-3 1914 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 2, 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1914, to November 2, 1914
that I last saw her alive on November 1, 1914
and that death occurred on the date stated above, at 2:40 P.M.
The CAUSE OF DEATH* was as follows: Carcinoma of uterus

..... (Duration) ..... yrs. 11 mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D C Ray M. D.
11/3 1914 (Address) Malad, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho.
DATE OF BURIAL: Nov. 5, 1914

20. UNDERTAKER: D. E. Johnson
ADDRESS: Malad, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. .... St.)

File No. 1914
Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ownids
City of St John
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nettie Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (If married, widowed or divorced, write the word.): Married

6. DATE OF BIRTH.
April (Month) 20 (Day) 1862 (Year)

7. AGE
52 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Home wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Wales

10. NAME OF FATHER: Samuel J Morgan.

11. BIRTHPLACE OF FATHER
(State or Country) Wales.

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W S Pierce
(Address) Malad R F D # 1

15.
Filed 11-18 1914
J C Ray
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1914, to Nov 8 1914, that I last saw her alive on Nov 8 1914, and that death occured on the date stated above, at 6A. M.

The CAUSE OF DEATH* was as follows:
Melonchalia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Suicide - by hanging

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J C Ray M. D.
11-18 1914 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. John Idaho — DATE OF BURIAL: Nov 19 1914

20. UNDERTAKER: W. E. Johnson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of Oneida

Primary Registration District No. 2069

City of Malad

(No. ....., ... St.)

File No. 1317

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josie Pridgen Thomas

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

July (Month) 28 (Day) 1891 (Year)

7. AGE

23 yrs. 3 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad, Idaho

10. NAME OF FATHER David D. Thomas

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Alice Pridgen

13. BIRTHPLACE OF MOTHER (State or Country) Malad, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Pridgen Thomas

(Address) Malad, Idaho

15.

Filed 11-21 1914 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1914, to Nov 20 1914, that I last saw h[illegible] alive on Nov 20 1914, and that death occurred on the date stated above, at 9:50 M.

The CAUSE OF DEATH* was as follows:

pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

11-21 1914 (Address) D C Ray

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Idaho	Nov 23 1914
20. UNDERTAKER	ADDRESS
W S Johnson	Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 9545

Name Jesse D. Thomas

Date of Death 11-20-14

Cause of Death Lobar pneumonia

Contributary Cause of death

(Sign here) D C Ray M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 1.3044
Registered No. 55

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha J. Phillips
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May 6 1907 (Month) (Day) (Year)

7. AGE: 7 yrs. 6 mos. 26 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Ogden Utah

10. NAME OF FATHER: Charles W. Phillips

11. BIRTHPLACE OF FATHER (State or Country): Lehi Utah.

12. MAIDEN NAME OF MOTHER: Elizabeth A. Francis

13. BIRTHPLACE OF MOTHER (State or Country): North Ogden Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. W. Phillips
(Address) Malad

15.
Filed 12-2 1914 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1914, to Dec 2 1914, that I last saw her alive on Dec 2 1914, and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:
Injury - fracture base of skull

(Duration) yrs. mos. ds.
Contributory (Secondary) Meningitis
(Duration) yrs. mos. ds.

(Signed) D C Ray M. D.
12 2 1914 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad, Ida
DATE OF BURIAL: Dec 4 1914

20. UNDERTAKER: W. S. Johnson
ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 3512
Registered No. 56

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carolin Leigh
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 2 (Day) 1914 (Year)

7. AGE: ____ yrs. 2 mos. 1 ds.
IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Idaho.

10. NAME OF FATHER: Joseph Leigh

11. BIRTHPLACE OF FATHER (State or Country): Malad Idaho

12. MAIDEN NAME OF MOTHER: Elizabeth Jones.

13. BIRTHPLACE OF MOTHER (State or Country): America Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Leigh
(Address) Malad Idaho

15.
Filed 12-3 1914 J. C. Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914, to Dec 3 1914, that I last saw her alive on Dec 3 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) 4 yrs. ____ mos. ____ ds.

(Signed) J. F. Allen M. D.

12-3 1914 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Dec 4 1914

20. UNDERTAKER: W. S. Johnson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad

Registration District No. 36
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 1250
Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Daisy Godwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f
4. COLOR OR RACE: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Nov (Month) 29 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 17 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Malad Ida

10. NAME OF FATHER: Chas O Godwin

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Lizzie Draughon

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C A Godwin
(Address) Malad Ida

15. Filed Dec 11 1914 — D C Ray, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1914, to Dec 11 1914
that I last saw her alive on Dec 11 1914
and that death occurred on the date stated above, at Noon M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
12-12 1914 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad City Idaho — DATE OF BURIAL: 12-14 1914

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. [illegible]
Registered No. 40

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ephraim Thorpe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Dec (Month) 2 (Day) 1914 (Year)

7. AGE
..... yrs. ..... mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Malad.

10. NAME OF FATHER Ephriam Thorpe

11. BIRTHPLACE OF FATHER
(State or Country) Samaria Idaho

12. MAIDEN NAME OF MOTHER Jennett Thomas

13. BIRTHPLACE OF MOTHER
(State or Country) Malad, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDG
(Informant) Ephraim Thorpe
(Address) Malad, Idaho

15.
Filed 12-28 1914 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1914, to Dec 27 1914, that I last saw h[illegible] alive on Dec 27 1914, and that death occurred on the date stated above, at 1130 M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
12-28 1914 (Address) Malad City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Ida | DATE OF BURIAL: 12-29 1914

20. UNDERTAKER: None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

9552

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9552

1. PLACE OF DEATH.
County of Oneida
City of Malbrook (No. ..... St.)
Registration District No. 36
Primary Registration District No. 2071
Registered No. 41
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Madsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Feb. (Month) 10th (Day) 1841 (Year)

7. AGE: 73 yrs. 10 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Cris Madsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Hannah Jepsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. P. Christensen
(Address) Malad Idaho.

15.
Filed 12-31 1914
D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1914, to Dec 30 1914, that I last saw h.im alive on Dec 30 1914, and that death occurred on the date stated above, at 10:40 P.M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
12-31 1914 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Ida
DATE OF BURIAL: Jany 3 1915

20. UNDERTAKER: D E Johnson
ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Cambridge

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 1002
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Greene Rodgers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 11 (Day) 1850 (Year)

7. AGE: 64 yrs. mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montgomery Mo

10. NAME OF FATHER: James K Rodgers

11. BIRTHPLACE OF FATHER (State or Country): Mo Kentucky

12. MAIDEN NAME OF MOTHER: Mary Rebecca Boyce

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Rodgers
(Address) Cambridge, Idaho.

15. Filed Jan 1 1915 — O E Schmuck, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1912, to Dec 30 1914
that I last saw him alive on Dec 30 1914
and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Cerebellum

(Duration) 2 yrs. mos. ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Schmuck M. D.
Jan 1 1915 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: Jan 1 1915

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. .....

1. PLACE OF DEATH. Registration District No. 85
County of Washington Primary Registration District No. 8164
City of Cambridge (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Roscoe Pennand

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Nov (Month) 20 (Day) 1836 (Year)

7. AGE: 78 yrs. 1 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Louisiana

10. NAME OF FATHER: Crewe

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Chas Burton
(Address) Parma Idaho

15. Filed Jan 1 1915 O E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1913, to Dec 29 1914
that I last saw him alive on Dec 29 1914
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(Duration) 1 yrs. 3 mos. ..... ds.
Contributory Arteriosclerosis
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Schmutz M. D.
Jan 1 1915 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho — DATE OF BURIAL: Jan 1 1915

20. UNDERTAKER: Jas Huddelson — ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington Co
City of Salubria

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 1936
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susana Starr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 5 (Day) 1827 (Year)

7. AGE: 77 yrs. 6 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Harris

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto E Anderson
(Address) Indian Valley Ida

15.
Filed Dec / 1914
O E Schmitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1914, to Nov. 14 1914
that I last saw her alive on Nov 13 1914
and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E Brown M. D.
12 - 1 - 1914 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. * In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Salubria Ida
DATE OF BURIAL: Nov 15 1914

20. UNDERTAKER: J A Hutchison
ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 55
County of Washington Primary Registration District No. 2164
City of Cambridge (No. ....., ... St.)
File No. 1994
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mable Helen Carlile

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: June (Month) 8 (Day) 1911 (Year)

7. AGE: 3 yrs. 4 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Cambridge Ida

10. NAME OF FATHER: Jos Carlile

11. BIRTHPLACE OF FATHER (State or Country): Iron Mtn Ark

12. MAIDEN NAME OF MOTHER: Clara Lawrence

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. T. Carlile
(Address) Cambridge

15. Filed Oct 26 1915 C E Schmutz, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1914, to Oct 26 1914
that I last saw her alive on Oct 26 1914
and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Fell in a spring
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Schmutz M. D.
Oct 26 1914 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge
DATE OF BURIAL: Oct 26 1914

20. UNDERTAKER: Jas Hendelson
ADDRESS: Cambridge Ida

MARGIN RESERVED FOR BINDING

...TE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
...em of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
...ould state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
... of OCCUPATION is very important. See instructions on back of certificate.

...S-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

County of Lincoln

Primary Registration District No. 1017–2017

City of Jerome (No. ....., ... St.)

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles H Avery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH: Mar (Month) 26 (Day) 1892 (Year)

7. AGE: 22 yrs. 4 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Randolph Neb

10. NAME OF FATHER: Frank Avery

11. BIRTHPLACE OF FATHER (State or Country): Seneca, Kas

12. MAIDEN NAME OF MOTHER: Jennie Buck

13. BIRTHPLACE OF MOTHER (State or Country): DeWitt, Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jennie Avery
(Address) Jerome Idaho

15.
Filed Aug 19 1914 E. D. Pifer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1914, to Aug 18 1914, that I last saw h[illegible] alive on Aug 18 1914, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Acute Inflammation of Bowel
(Duration) — yrs. 1 mos. — ds.
Contributory (Secondary) Peritonitis
(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) E. D. Pifer M. D.
8/19 1914 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary — DATE OF BURIAL: Aug 19 1914

20. UNDERTAKER: D. W. Harrison — ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017

File No. 1111

Registered No. .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Elsie Freeman Yeoman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1 (Year)

7. AGE: 57 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ills.

10. NAME OF FATHER: Mark Yeoman

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Brown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella Yeoman
(Address) Jerome

15. Filed Oct 1 1914 E. D. Pfau
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1914, to Sept 9 1914 that I last saw h[illegible] alive on Sept 9 1914, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. D. Pfau M. D.

Sept 9 1914 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: Sept 11 1914

20. UNDERTAKER: [illegible] Jerome — ADDRESS

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Harte.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2051
(No. ....., ... St.)

File No. 9562
Registered No. 426
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gilbert Beckman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S.

6. DATE OF BIRTH June (Month) 8 (Day) 1914 (Year)

7. AGE ..... yrs. 7 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Boy
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry Beckman

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Lena Swallow

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D D D
(Address) Rathdrum

15. Filed 1/10 1915 D D Freeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH dec. (Month) 29 (Day) 191X (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1914, to Dec. 19 1914, that I last saw h[illegible] alive on 11 10 191X and that death occurred on the date stated above, at 6. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Freeman M. D.

1/20 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL C. E. Bobo | DATE OF BURIAL Dec 21 191X

20. UNDERTAKER | ADDRESS Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

17

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. 2051

File No. 9563

County of Kootenai

City of Rathdrum (No. ....., ... St.)

Registered No. 442

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Case

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH

..... (Month) 1 (Day) ..... (Year)

7. AGE

50 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mich

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D Morris

(Address) Rathdrum Ida

15.

Filed 1/10 1915 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec (Month) 16 (Day) 191X (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 191X, to Dec 16 191X, that I last saw h alive on Dec 9 191X, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cauty Acidosis
Contusion of Liver

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drennan M. D.

12/16 191X (Address) Rp

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) None

At place of death ..... yrs. 9 mos. 16 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? —

Former or usual residence Rpsh

19. PLACE OF ~~BURIAL~~ OR REMOVAL Lansing Mich | DATE OF BURIAL ..... 191...

20. UNDERTAKER Corbit & Lee | ADDRESS Rp

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

County of Kootenai

Primary Registration District No. 2051

City of Parkdale

(No. ....., ... St.)

File No. 1116

Registered No. 444

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Malissa Fuller

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: July (Month) 27 (Day) 1824 (Year)

7. AGE: 90 yrs. 4 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: H. W.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burt Fuller
(Address) Post Falls

15.
Filed 1/10 1915 D S Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 3 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914 to Dec 3 1914 that I last saw h alive on 4 1 1914, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Brennan M. D.

12/4 1914. (Address) Parkdale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls

DATE OF BURIAL: 12/5 1914

20. UNDERTAKER: Gone

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

Primary Registration District No. 2051

File No. 1,111

Registered No. 448

County of Kootenai

City of Rathdrum (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Unnamed) Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: Novbr. 15. 1914 (Month) (Day) (Year)

7. AGE: — yrs. — mos. — ds. 15½ IF LESS than 1 day how many 15 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rathdrum, Ida.

10. NAME OF FATHER: Charles H. Davis

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Edith M. Jinkinson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. H. Davis
(Address) Rathdrum, Ida.

15. Filed Dec 10 1915 L. J. Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Novbr. (Month) 15. (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Novbr. 15 191 4, to Novbr. 15 191 4, that I last saw h[illegible] alive on Nov. 15. 191 4 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Kenny M. D.

11/16 1914 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum — DATE OF BURIAL: Nov 16, 1914

20. UNDERTAKER: None — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1044 24
County of Gooding Primary Registration District No. 014 File No. 4016
City of Gooding (No. ....., ... St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Queen Rordell
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: May (Month) 17 (Day) 1913 (Year)

7. AGE: 1 yrs. 4 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Gooding Idaho

10. NAME OF FATHER: Marius Rordell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marius Rordell
(Address) Gooding Idaho

15.
Filed 10-3 1914 H. T. Cary M.D., Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-21- 1914, to 10-2 1914
that I last saw him alive on 10-2 1914,
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Mucus Colitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. T. Cary M. D.
Oct 3 1914 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho — DATE OF BURIAL: 10-4 1914

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

YMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9567
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1014
Primary Registration District No. 1024
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Hannah Carpenter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH.
June (Month) 11 (Day) 1848 (Year)

7. AGE
66 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Mass

10. NAME OF FATHER
French

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER
Tucker

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cora Carpenter
(Address) Gooding Idaho.

15.
Filed Jan 2 1915
T. T. Cary M.D.
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1914, to Sept 23 1914, that I last saw h[illegible] alive on 9-23- 1914, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Complicated by acute nephritis
(Duration) Yrs. 2 mos. 13 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) T. T. Cary M. D.
Jan 3 1915 (Address) Gooding Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding
DATE OF BURIAL: 9-29 1914

20. UNDERTAKER: G. E. Thompson
ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1014
Primary Registration District No. 1024
(No. ....., ... St.)

File No. 9568
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charles Phil Bigham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: September 8 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. ~ mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C E Bigham

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Emma Phl

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Bigham
(Address) Gooding Idaho

15. Filed Jan 2 1914 F. T. Carey M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1914, to Sept 10 1914, that I last saw him alive on Sept 10 1914, and that death occurred on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:
Patent Foramen Ovale
Patent Ductus Arteriosus
..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cranmell M. D.
Sept 10 1914 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds
In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding
DATE OF BURIAL: Sept 11 1914

20. UNDERTAKER: C. E. Thompson
ADDRESS: Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 18172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gooding
City of Bliss
(No. ....., ... St.)

Registration District No. 1014 24
Primary Registration District No. 1014
File No. 1111
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George T Shay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1842 (Year)

7. AGE: 72 yrs. 0 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Benjamin Shay

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Wrighter

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Shay
(Address) Bliss Ida

15.
Filed Sept 11 1914 F. T. Cary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1914, to Sept 8th 1914, that I last saw him alive on Sept 3rd 1914, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cranmer M. D.
Sept 11 1914 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hagerman — DATE OF BURIAL: 10th 1914

20. UNDERTAKER: G. E. Tompkins — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 1014

Primary Registration District No. 1024

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Masterson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dont Know (Month) (Day) 1 (Year)

7. AGE: about 40 years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Elgin Ill

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Patterson

(Address) Bliss Idaho.

15.

Filed Aug 9 — 8 — 1914

F. T. Carey M. D.
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 (Month) — 4 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8 — 4 — 1914, to 8 — 4 — 1914, that I last saw h[illegible] alive on 7 — 29 — 1914, and that death occured on the date stated above, at 11 45 A.M.

The CAUSE OF DEATH* was as follows:

Fell from load of hay striking side of head and upon impact broke neck & killed instantly

(Duration) one Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. T. Carey M. D.

19..... (Address) Gooding Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elgin Ill. DATE OF BURIAL: 8 — 5 — 1914

20. UNDERTAKER: A. E. Thompson ADDRESS: Gooding

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 1014

Primary Registration District No. 2014

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1144

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Gooding

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Howard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1914 (Year)

7. AGE: .....Yrs. .....Mos. 7 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Gooding

10. NAME OF FATHER: E. V. Howard

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma P. Rasmussen

13. BIRTHPLACE OF MOTHER (State or Country): Den Mark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. V. Howard

(Address) Gooding

15.

Filed Jan 2 1915

T. T. Carey M.D.
Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1914, to Nov 1 1914, that I last saw h[illegible] alive on Nov 1 1914, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus Inflamation of the Bowels,

(Duration) .....Yrs. .....mos. 7 ds.

Contributory (Secondary) .....

(Duration .....yrs. .....mos. .....ds.

(Signed) T. T. Carey M. D.

Jan 2 1915 (Address) Gooding Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: Nov 2, 1914

20. UNDERTAKER: C. E. Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9572

Registered No. 4

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Blaine
City of Soldier
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2/58

2. FULL NAME Edward Walsh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE: 50 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Attorney at Law
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ackwa Ohio

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Peterson
(Address) Goodwin Idaho

15.
Filed 7-25-14 191.. F Hoyt MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1914, to July 22 1914
that I last saw h-- alive on July 22 1914,
and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Was thrown from wagon and Spinal cord injured + Compound fracture left arm
..... (Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Aldrich M. D.
July 25 1914 (Address) Soldier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portsmouth Ohio
DATE OF BURIAL: 7-25 1914

20. UNDERTAKER: A E Thompson
ADDRESS: Goodwin Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 111

Registered No. 49

County of Ada

City of Boise Near Boise No. Carsons Ranch near Boise St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William S. Middlemiss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec 7 (Month) (Day) 1854 (Year)

7. AGE: 60 Yrs. — Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: William Middlemiss

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Yates

(Address) Marysville Kan

15. Filed 12-24 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1914, to Dec 19 1914, that I last saw h.. alive on Dec 15 1914, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

acute Alcoholism and
weak heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Weak heart

(Duration Unknown) ..... mos. ..... ds.

(Signed) C B Galland M. D.

12/24 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 24 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
(No. Blacks Creek Ada County)

File No. 1113
Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Edward Shawver

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 2nd (Day) 1914 (Year)

7. AGE: ....yrs. 2 mos. ....ds.
IF LESS than 1 day how many .....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada County. Idaho

10. NAME OF FATHER: Ray P. Shawver

11. BIRTHPLACE OF FATHER (State or Country): Mont

12. MAIDEN NAME OF MOTHER: Olive Michel

13. BIRTHPLACE OF MOTHER (State or Country): Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Shawver
(Address) Blacks Creek

15.
Filed 12-30 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 30th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from DEC 21 1914, to DEC 30 1914
that I last saw him alive on Dec 29 1914
and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Bronchio-pneumonia

(Duration) ....yrs. ....mos. 4 ds.

Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J Carl Hill M. D.
Dec 30 1914 (Address) Boise - Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs ....mos ....ds.
In the State ....yrs ....mos ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Ada County. Ida.

19. PLACE OF BURIAL OR REMOVAL / DATE OF BURIAL
Morris Hill Cemetery 12/31 1914

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

City of Boise (No. Soldiers Home St.) Registered No. [illegible]

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W Harrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Not Obtainable (Month) 1 (Day) 1846 (Year)

7. AGE: 68 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil
(b) General nature of industry, business, or establishment in which employed (or employer): War

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. G. Burnett
(Address) Soldiers' Home

15. Filed Dec. 26th, 1914 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/10 1914, to 12/25 1914, that I last saw h~~e~~ alive on 12/25 1914, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ... Yrs. 11 mos. ... ds.

Contributory (Secondary) Arteriosclerosis

(Duration ... yrs ... mos ... ds.

(Signed) Fred A Tuttle M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Dec 27 1914

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & RDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

(No. Soldiers Home. St.)

File No. [illegible]

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles W Cagle.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) 1937 (Year)

7. AGE: 77 Yrs. ___ Mos. ___ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Veteran war of 1855

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E L Burnett

(Address) Soldiers Home

15. Filed Dec 1 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1914, to Nov 30 1914 that I last saw h[illegible] alive on Nov 30 1914 and that death occured on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred Steinegger M. D.

12/1 1914 (Address) Salt Lake City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris View Cemetery — DATE OF BURIAL: Dec 2 1914

20. UNDERTAKER: Troy & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKBS. 24653

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. [illegible]53

1. PLACE OF DEATH. Registration District No. 8

County of Ada Primary Registration District No. 2004

City of Boise (No. Idaho State Prison St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew H Aldrich

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1848 (Year)

7. AGE: 66 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): not obtainable

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): not obtainable

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Groom
(Address) Boise, Idaho

15. Filed Dec. 26th, 1914 C. S. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1914, to Dec 24 1914
that I last saw h[illegible] alive on Dec 20 1914
and that death occurred on the date stated above [illegible] P. M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jm Caruth M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bannock Ferry Idaho — DATE OF BURIAL: 12/27 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1114

Registered No. 287

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. Stay Rooming House)

2. FULL NAME John Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: White
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Not obtainable (Write the word.)

6. DATE OF BIRTH: Not obtainable (Month) (Day) (Year)

7. AGE: About 31 years ... mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Not obtainable
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not obtainable

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Schnitter
(Address) Boise

15. Filed Dec 1 1914 — W S Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ ~~191~~ to saw ~~191~~ ~~that I last saw h alive on~~ dead Nov. 29½ 1914 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Catolic Acid Poisoning
Suicide
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Adolph Schnitter Coroner M. D.
19... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Co. Plat
DATE OF BURIAL: Dec 1 1914

20. UNDERTAKER: Schnitter & Sidenfaden
ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9580

Registered No. 288

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 711, Idaho St.)

Registration District No. 2
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gee Yine Fon Wa

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 13 (Month) (Day) 1857 (Year)

7. AGE: 57 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Yot Jung

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Tom C

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. H. Gim
(Address):

15. Filed Dec 1 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 26th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1914, to Nov 25 1914, that I last saw him alive on Nov 25 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Bright's

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ruth Falk M. D.
11/28 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery
DATE OF BURIAL: 12/1 1914

20. UNDERTAKER: Schneider & Wedemeyer
ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada.

City of Boise (No. 1 St. & Main St. St.)

File No. [redacted]

Registered No. 290

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret E. Fordyce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. — (Month) — (Day) 1851 (Year)

7. AGE: 63 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ohio,

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L L Ormsby

(Address) Boise Idaho

15. Filed Dec 2 1914 — M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) First (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1914, to Dec 1st 1914, that I last saw her alive on Dec 1st 1914, and that death occured on the date stated above, at 8. P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Smith M. D.

12/2 1914 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portland Ore. DATE OF BURIAL 191

20. UNDERTAKER: Frye & Summers ADDRESS Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRON - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1582
Registered No. 292

1. PLACE OF DEATH.
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. 119 Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Bayhouse

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: October (Month) 27th (Day) 1836 (Year)

7. AGE: 78 yrs. 1 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Schleswig Holstein
Statendorf, Schleswig-Holstein, Germany

10. NAME OF FATHER: Gottch Gottch

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George W. Smith
(Address) 119 Main St. - Boise, Idaho.

15.
Filed 12-5 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 4th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24th 1914, to Dec 4th 1914
that I last saw her alive on Dec 4 191
and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Smith M. D.
12/4 1914 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence. Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery
DATE OF BURIAL: 12/5 1914

20. UNDERTAKER: Schreiber & Siedenfaden
ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. St Lukes Hospital St.)

File No. 1118

Registered No. 293

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Welsh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH. June (Month) 7 (Day) 1863 (Year)

7. AGE 51 Yrs. 6 Mos. 0 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER George Welsh

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Mary Martin

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs David Welsh
(Address) Parma Ida

15. Filed 12-7 1914 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1914, to Dec 7 1914, that I last saw h[illegible] alive on Dec 6 1914 and that death occured on the date stated above, at 2.45 A M.

The CAUSE OF DEATH* was as follows:
Thromboais of superior mesenteric artery

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) myocarditis
(Duration yrs. mos. ds.

(Signed) J S Purrington M. D.
[illegible] 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 1 ... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? Parma Ida
Former or usual residence Parma Ida

19. PLACE OF BURIAL OR REMOVAL Parma Ida — DATE OF BURIAL Dec 9 1914

20. UNDERTAKER Frey & Summers — ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 2. 1913. M. 6-11 — CERTIFICATE OF DEATH — State of Idaho — BOARD OF HEALTH — Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 2

County of Ada — Primary Registration District No. 1004 — File No. 9[illegible]

City of Boise — (No. 412, State St.) — Registered No. 295

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William L. Barnes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 10th (Day) 1870 (Year)

7. AGE: 43 yrs. 1 mos. 28 ds. — IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: W. Barnes

11. BIRTHPLACE OF FATHER (State or Country): not Obtainable

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marion Barnes
(Address) 1122 Grand Ave

15.
Filed 12-10 1914 — W. S. Parker — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 9th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20 1914, to Dec 9 1914, that I last saw h[illegible] alive on Dec 9 1914 and that death occurred on the date stated above, at 1. A. M.

The CAUSE OF DEATH* was as follows: Nephritis, Chronic Parenchymatous

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. S. Parker M. D.
Dec 10 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death St Alphonsus ..... yrs. ..... mos. 2 ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence. Boise Idaho. 1122 Grand Ave

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/11 1914

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5.* 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 412 State St.)

File No. 1053
Registered No. 296

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M Kane

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1867 (Year)

7. AGE: 46 yrs. 11 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: James Kane

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizth McKay

13. BIRTHPLACE OF MOTHER (State or Country): Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Will G. Rogers
(Address)

15.
Filed 12-11 1914 M S Parker Local Registrar
Dr. Collister

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 10th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia terminal

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo Collister M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place St Alphonsus in the
of death ..... yrs ..... mos. 11 ds. State ..... yrs ..... mos ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence. Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery DATE OF BURIAL: 12/12 1914

20. UNDERTAKER: Schrader & Sidenfaden ADDRESS: Boise Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

SITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
y item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form No. 5. Rev. 1914-11

CERTIFICATE OF DEATH

State of Idaho
BUREAU OF VITAL STATISTICS
Department of Public Welfare

State of Idaho
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 104
(No. 20 2nd Street St.)

File No. 9586
Registered No. 298

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edgar L Bush

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb 9th (Month) (Day) 1874 (Year)

7. AGE: 40 yrs. 10 mos. 1 ds. IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jefferson City Mo

10. NAME OF FATHER: Martin Bush

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Francis N. Lister

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W R Carver
(Address)

15.
Filed 12-14 1914
M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 10th (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to Dec 10 1914
that I last saw h- alive on Dec 9 1914
and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Laryngeal

(Duration) 9 yrs. mos. ds.
Contributory Tuberculosis Lungs
(Secondary)
(Duration) 2 yrs. mos. ds.

(Signed) R E Lynch M. D.
19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence: Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: 12/14 1914

20. UNDERTAKER: Schreiber & Siebenfaden
ADDRESS: Boise, Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada.

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1210 Bannock St.)

File No. [illegible]

Registered No. 299

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Wayman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Apr. (Month) 17 (Day) 1863 (Year)

7. AGE: 51 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Israel W. Martin.

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. W. Wayman

(Address) 1210 Bannock Boise

15.

Filed 12-16 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend to her for this trouble before
that I last saw her alive on Dec 13 1914
and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
(Sudden)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Smith M. D.

12/15 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill

DATE OF BURIAL: Dec 16 1914

20. UNDERTAKER: Terry & Summers

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

WING - YORK CO., PTRS. & STRS. 24658

Form B. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9388

Registered No. 300

1. PLACE OF DEATH. Registration District No. 2

County of Ada Primary Registration District No. 1004

City of Boise (No. 1602 Latah St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Oscar Thompson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 25 (Day) 1886 (Year)

7. AGE: 26 yrs. 7 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Earl E. Thompson

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Maria Rood

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed. E. Thompson
(Address) Boise

15. Filed 12-19 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead ~~Dec. 16 to Dec. 17~~ from 1914

that I last saw him alive on 16 Dec. 1914

and that death occurred on the date stated above, at ? M.

The CAUSE OF DEATH* was as follows: Has been subject to Epileptic fits since Child hood and succumbed to death in one (Duration) [redacted] yrs. — mos. — ds.

Contributory (Secondary) Epilepsy

(Duration) 22 yrs. mos. ds.

(Signed) Adolph Schreiber, ~~M. D.~~ Coroner

19 (Address) Boise Ada Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence: Washington

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec. 20 1914

20. UNDERTAKER: Schreiber & Hidenfeldt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ment of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1307

Registered No. 307

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1212 Front St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack Gifford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Divorced

6. DATE OF BIRTH. Nov (Month) 23 (Day) 1847 (Year)

7. AGE: 67 Yrs. 0 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Night Watch

(b) General nature of industry, business, or establishment in which employed (or employer): Saw Mill

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Burton Gifford

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Eliza Worrell

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W L Gifford

(Address) Boise Idaho

15.

Filed 12-20 1914

M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11th 1914, to Dec 18 1914, that I last saw him alive on Dec 18 1914, and that death occured on the date stated above, at 12 A M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Angina Pectoris

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A Sullens M. D.

12/19 1914 (Address) Idaho Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida — DATE OF BURIAL: Dec 22 1914

20. UNDERTAKER: Pyle & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
(No. ..... St.)
File No. .....
Registered No. 302

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna R. Sherman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 1 (Day) 1866 (Year)

7. AGE: 48 Yrs. 6 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Christian Paulson

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. L. Sherman
(Address) Boise Ida

15. Filed 12-21 1914 M S Parker Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1914, to Dec 20 1914, that I last saw h[illegible] alive on Dec 20 1914, and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
Post operative Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Pleurisy with Intestinal Trouble
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James L Stewart M. D.
19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. / ... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Victor Ida

19. PLACE OF BURIAL, OR REMOVAL: Caldwell Ida Canyon Hill Cem. | DATE OF BURIAL ..... 191...

20. UNDERTAKER: Pioneer Funeral Directors Chapman Care Co. | ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1191

Registered No. 303

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St Alphonsus Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 11 (Day) 1846 (Year)

7. AGE: 66 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Lars Lake

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emmeline Larson

(Address) 613 S 13 St.

15. Filed 12-23 1914 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914, to Dec 21 1914, that I last saw him alive on Dec 21 1914, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: (Uremia)

Chronic Nephritis

(Duration) Several Yrs. mos. ds.

Contributory (Secondary) Influenza Vulgaris

(Duration) yrs. Several mos. ds.

(Signed) W S Peters M. D.

12-22 1914 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? 613 S 13 St

Former or usual residence 613 S 13 St

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 23 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9592
Registered No. 305

1. PLACE OF DEATH.
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. 812 Resseguie St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James L Inglis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan. (Month) 26 (Day) 1852 (Year)

7. AGE: 62 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Master Mechanic
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): London England

10. NAME OF FATHER: William Inglis

11. BIRTHPLACE OF FATHER (State or Country): Forest Lane

12. MAIDEN NAME OF MOTHER: Sarah Pagdam

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James Inglis
(Address) Boise

15. Filed Dec. 26th, 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19th 1914, to Dec 23 1914 that I last saw h alive on Dec. 20th 1914 and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis Emphysema
Acute Bronchopneumonia
(Duration) — yrs. — mos. 6 ds.
Contributory Chronic Contracted Kidneys
(Secondary)
(Duration) 20 yrs. — mos. — ds.
(Signed) H Goodfrey M. D.
19 (Address) 120 Idaho St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F Cemetery — DATE OF BURIAL: Dec 26 1914

20. UNDERTAKER: Schreiber & Lieuallen — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [illegible]
Registered No. 306

1. PLACE OF DEATH.
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. Manston ave bet 3rd 4 St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Joel B. Bronson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 23rd (Day) 1834 (Year)

7. AGE: 80 yrs. 2 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired Carpenter
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salsbury Center N.Y.

10. NAME OF FATHER: Jadick Bronson

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Arille Benjamin

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Bronson
(Address)

15. Filed Dec. 26th, 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 25th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/13 1914, to 12/25 1914
that I last saw h[illegible] alive on 12/26 1914
and that death occurred on the date stated above, at 2:45 P.M.
The CAUSE OF DEATH* was as follows:

Pulmonary Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A Pettengill M. D.
12/26 1914 (Address) Idaho Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Do Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: 12/27 1914

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
(No. 3 th. & Lincoln st. Boise St.)
File No. 1101
Registered No. 307

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emmett D. Nash

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Divorced

6. DATE OF BIRTH. July (Month) 15 (Day) 1846 (Year)

7. AGE: 68 Yrs. 5 Mos. 10 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER W. N. Nash

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edwin V. Nash
(Address) Arrowrock

15.
Filed Dec. 26th, 1914
Local Registrar

SVMS - YORK CO., PTRS. & BRRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/25 1914, to 12/25 1914, that I last saw him alive on 12/25 1914 and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Fred A. Tyler M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 28 1914

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9595
Registered No. 310

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 1010 O Farrell St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Bayhouse

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) Eight (Day) 1826 (Year)

7. AGE: 88 yrs. 0 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Florist
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Bayhouse

11. BIRTHPLACE OF FATHER (State or Country): Holland - Rhine

12. MAIDEN NAME OF MOTHER: Lelara

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Bayhouse
(Address) 1010 O'Farrell, Boise

15.
Filed 12-28 1914
W S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Two weeks, 1914, to Dec 28 1914
that I last saw him alive on Dec 28 1914
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W B Smith M. D.
12/28 1914 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery
DATE OF BURIAL: Dec 29 1914

20. UNDERTAKER: Schreiber & Sidwell
ADDRESS: Boise.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE. 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27

County of Franklin Primary Registration District No. 2119

City of Preston (No. ....., ... St.)

File No. .....

Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (*Write* the word.)

6. DATE OF BIRTH: Dec. (Month) 12th (Day) 1914 (Year)

7. AGE ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Preston Ida.

10. NAME OF FATHER: Arnold Hofoed

11. BIRTHPLACE OF FATHER (State or Country): Weston Ida.

12. MAIDEN NAME OF MOTHER: Etna Stephenson

13. BIRTHPLACE OF MOTHER (State or Country): Preston Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Etna Hofoed
(Address) Preston Ida

15. Filed Jan. 10 1915 Allen Builter Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/12 1914 to 12/12 1914, that I last saw h~~im~~live on 12/12 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* ~~was~~ as follows:

[redacted] Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds. 1/2 hr

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. C. Parkinson M.D.

19 ..... (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston | DATE OF BURIAL: 12/12 1914

20. UNDERTAKER: None | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 9598
Registered No. 68
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christian Monson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED.~~ (Write the word.): Married

6. DATE OF BIRTH: May (Month) 22 (Day) 1860 (Year)

7. AGE: 54 yrs. ..... mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lehi Utah

10. NAME OF FATHER: Christian Monson Dec

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Sena Curtis Buck

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Lorna Monson.
(Address) Preston Ida

15. Filed Jan. 18 1915 Allen R Culter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1914 to June 4 1914 that I last saw him alive on June 4 1914 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Two yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. G. Parkinson M. D.
19..... (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: June 7 1914

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9599

Registered No. 80

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 124

Primary Registration District No. 2194

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Missouri Meeker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 7 (Day) 1848 (Year)

7. AGE: 66 Yrs. 2 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: W. L. Brown

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Lucy Brown

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. P. Hendron

(Address) Blackfoot, Route 4

15. Filed Dec 5 1914 M. E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ last attended deceased from ..... 191..., to ..... 191..., ~~that I last saw him alive on~~ ..... 191..., and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. E. Petrie M. D.

12-4 1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: Dec 6 1914

20. UNDERTAKER: D. P. Hendron — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 1907

City of Blackfoot (No. 382 South Stout St.)

File No. 1111

Registered No. 81

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James C. Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1834 (Year)

7. AGE: 80 yrs. 1 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Milton Fisher

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Sarah Tremper

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. T. Fisher
(Address) Blackfoot Idaho

15. Filed Dec 9 1914 M. E. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1914 to Dec. 8 1914 that I last saw him alive on Dec. 8 1914 and that death occurred on the date stated above, at 3. P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Fremont Hall M. D.

12/8-1914 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot, Idaho. DATE OF BURIAL: Dec 10 1914

20. UNDERTAKER: E J Peck ADDRESS: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

File No. 1111

Registered No. 72

County of Bingham

City of Springfield (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sterling Edward Stevenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	W Cole	Single

6. DATE OF BIRTH: July (Month) 24 (Day) 1914 (Year)

7. AGE: yrs. 4 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Boulton Salt Lake Co Utah

10. NAME OF FATHER H B Stevenson

11. BIRTHPLACE OF FATHER (State or Country) Bunlia S.L. Co. Utah

12. MAIDEN NAME OF MOTHER Nellie Brotherton

13. BIRTHPLACE OF MOTHER (State or Country) Holliday Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H B Stevenson
(Address) Murray Utah R.D. #4

15. Filed Dec 14 1914 M E Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1914, to Dec 11 1914, that I last saw h[illegible] alive on Dec 11 1914, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M Cranston M. D.

Dec 12 1914 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City — DATE OF BURIAL ..... 191...

20. UNDERTAKER: E J Peck — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

County of Bingham

City of Blackfoot (No. Blackfoot Hospital St.)

File No. 83

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruby A Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH

7 (Month) 25 (Day) 1889 (Year)

7. AGE

25 yrs. 4 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Nurse

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ammon Hansen

11. BIRTHPLACE OF FATHER (State or Country) Soda Springs Idaho

12. MAIDEN NAME OF MOTHER Barnard Lillian Vaughan

13. BIRTHPLACE OF MOTHER (State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R E Hansen

(Address) Blackfoot Ida

15.

Filed Dec 19 1914 M E Sutrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Poison administered by her own hand, (Suicidal)

verdict of Coroners Jury.

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E J Funk Coroner M. D.

19 0 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sunbeam Cemetery

DATE OF BURIAL: ..... 191...

20. UNDERTAKER: E J Funk

ADDRESS: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Moreland
Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)
File No. .....
Registered No. 84
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel Ann Simmett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Dec. (Month) 5 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bingham Co. Idaho

10. NAME OF FATHER: Hyrum Simmett

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Ann Slaugh

13. BIRTHPLACE OF MOTHER (State or Country): ~~Utah~~ Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hyrum Simmett
(Address) Blackfoot Route #2

15. Filed Dec 16 1914 W. G. Jahn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Dec 16 1914, ~~to~~ ~~1914~~, ~~that I last saw h~~ ~~alive on~~ ~~1914~~, and that death occured on the date stated above, at 1:35 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. G. Jahn M. D.
12-16-1914 (Address) Local Registrar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: Dec 17 1914

20. UNDERTAKER: Hyrum Simmett — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121

County of Bingham Primary Registration District No. 2194

City of Blackfoot (No. ....., ... St.) File No. 1601

R F D 4 Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Welthy M. Baxter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Feb (Month) 13 (Day) 1862 (Year)

7. AGE: 52 yrs. 10 mos. 4 ds. IF LESS than 1 day how ~~many~~ ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Carlos S. Higgins

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Dortea Christenson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Davis MD
(Address) Blackfoot Ida

15. Filed Dec 18 1914 M. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1914, to Dec 17 1914
that I last saw her alive on 17 Dec 1914
and that death occurred on the date stated above, at 3.10 P.M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

..... (Duration) 15 yrs. — mos. — ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Davis M. D.
12-18 1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Ida. DATE OF BURIAL: Dec 20 1914

20. UNDERTAKER: Mrs A. J. Oliver ADDRESS: Ancs Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. 86

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

(No. West Luella St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fay Martindale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Dec (Month) 11 (Day) 1914 (Year)

7. AGE ....Yrs....Mos. 9 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Blackfoot Idaho

10. NAME OF FATHER Wm Alexander Martindale

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Jennie Brown

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X Wm A. Martindale

(Address) Blackfoot Idaho

15. Filed Dec 19 1914

M E Petrie
Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1914, to Dec 19 1914, that I last saw her alive on Dec 18 1914, and that death occured on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(Duration) Yrs. mos. ds.

Contributory (Secondary) M. C. Petrie

(Duration) Yrs. mos. ds.

(Signed) M E Petrie M. D.

12/19/1914 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida — DATE OF BURIAL 191

20. UNDERTAKER: X Wm A. Martindale — ADDRESS Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Wapello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12/

Primary Registration District No. 2194

(No. ....., ... St.)

File No. 1016

Registered No. 85

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva L Jameson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH.

Nov (Month) 20 (Day) 1875 (Year)

7. AGE

39 Yrs. / Mos. / ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Perry Marshall

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Harris

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Jameson

(Address) .....

15.

Filed Dec 25 1914 W. E. Pahie Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21 1914, to Dec. 21 1914, that I last saw him alive on Dec. 21 1914, and that death occured on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Uremia.

(Duration) - Yrs. - mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Mitchell M. D.

12/21 1914 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sum city cemetery	Dec 24 1914
20. UNDERTAKER E J Funk	ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1111

Registered No. 78

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 1007

(No. Blackfoot Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha McElveen.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 29 (Day) 1880 (Year)

7. AGE: 34 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: — Babcock

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur McElveen

(Address) Adams Street Blackfoot

15. Filed Dec. 25 191 4 W. E. Pattie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1914, to Dec 23 1914, that I last saw her alive on Dec 23 1914, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Pyo Salpinx.

Shock following operation for Pyo Salpinx.

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Salpingitis

(Duration yrs. mos. ds.

(Signed) H. J. Simmons M. D.

12/26 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fern Hill Cemetery — DATE OF BURIAL: Dec 27 1914

20. UNDERTAKER: E. J. Burk — ADDRESS: Blackfoot

BYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Wapello

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

File No. 1111

Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Russell Peterson Tucker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. July (Month) 29 (Day) 1846 (Year)

7. AGE: 68 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Lars Anderson.

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Johanna Evanrud

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Peterson

(Address) R 3 B x 30 Blackfoot

15. Filed Jan 1 1915

M. E. Tabit
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1914, to Dec 30 1914, that I last saw he alive on Dec 29 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hemorrhoids

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Sorensen M. D.

12/31/1914 (Address) Black foot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairmont Utah

DATE OF BURIAL: ..... 191...

20. UNDERTAKER: E J Peck

ADDRESS: Blackfoot Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Shelley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)

File No. 9609
Registered No. 90
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilda Belle Morrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	Single

6. DATE OF BIRTH
Oct 30 1914
(Month) (Day) (Year)

7. AGE
— yrs. 2 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry W Morrison

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Gertrude Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry W Morrison
(Address) Shelley Ida

15. Filed Jan 1 1915 W. E. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 31 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1914, to Dec 31 1914, that I last saw h[illegible] alive on Dec 31 1914 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) — yrs. — mos. 4 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Edward Turner M. D.
Jan 1 1915 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lincoln County | DATE OF BURIAL: Jan 2nd 1915

20. UNDERTAKER: E J Link | ADDRESS: Blackfoot

SYMS - YORK CO. PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 1011
Registered No. 11

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Dorthy Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. Oct 18 (Month) Dec 2 (Day) 1831 (Year)
7. AGE: 78 Yrs. 2 Mos. 13 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Denmark
10. NAME OF FATHER: Michael Jeppesen
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Anna K. Jeppesen
13. BIRTHPLACE OF MOTHER (State or Country): Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) + Henry Young
(Address) Blackfoot Route 1
15. Filed Dec 31 1914 W. E. Pettit Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I ~~attended deceased from~~ from Injured death 191..., to ..... 191..., ~~that I last saw deceased alive on~~ ..... 191..., and that death occured on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:
Old age pc
.....
.....
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration) .....Yrs. .....mos. .....ds.
(Signed) W. E. Pettit M. D.
12/31/1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groveland Idaho — DATE OF BURIAL: Jan 2 1915
20. UNDERTAKER: + Henry Young — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & SONS. 24658

M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of McCammon

Registration District No. 11
Primary Registration District No. 2047
(No. ....., ... St.)

File No. 1011
Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Andrews.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 10 (Day) 1911 (Year)

7. AGE: 3 yrs. 1 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Tennessee.

10. NAME OF FATHER: Frank Andrews.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Brown

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Andrews
(Address) Father McCammon

15.
Filed Dec 10, 1914 Ed Kaney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 (Month) — 23 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw h— alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Killed.
Run over with Wagon.
Fracture base of Skull.
(Duration) — yrs. — mos. — ds.
Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.
(Signed) G H Cope M. D.
11/24 1914 (Address) McCammon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: McCammon
DATE OF BURIAL: Nov 28 1914

20. UNDERTAKER: Walla & Winn
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of McCammon

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11

Primary Registration District No. 2047

(No. ....., ... St.)

File No. 1401

Registered No. 47

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME —

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	W.	

6. DATE OF BIRTH: 11 (Month) — 20 (Day) — 14 (Year)

7. AGE: — yrs. — mos. — ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) — —

9. BIRTHPLACE (State or Country) McCammon Ida

10. NAME OF FATHER Alec. Pierce

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Gammie

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alec. Pierce
(Address) McCammon Ida

15. Filed Dec 10, 1914 Ellis Kay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 (Month) — 20 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-20-1914, to 11-20-1914, that I last saw h[illegible] alive on 11-20-1914, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery from Birth

Dysentery 2 Pneumogastric nerve

Paralysis cardiac Respiration

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Cooper M. D.

19.... (Address) McCammon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
McCammon	Nov 20 1914
20. UNDERTAKER	ADDRESS
None	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Canyon

Primary Registration District No. 1008

City of Nine Plymouth (No. ....., ... St.)

File No. 111

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Sarah Mercer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Sept. (Month) 6th (Day) 1830 (Year)

7. AGE: 84 yrs. 3 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer): Widow

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Elisha Freel

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Mercer.

(Address) Nine Plymouth

15. Filed Dec 8 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 6th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 6, 8 P.M. 1914, to Dec 6th 9.30 A.M. 1914, that I last saw her alive on Dec 6th 9.30 A.M. 1914, and that death occurred on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexia)

..... (Duration) ..... yrs. ..... mos. 2 hours ds.

Contributory (Secondary): Old age + Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Crispin Coniphe M. D.

Dec 7 1914 (Address) Fruitland, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence: Removal

19. PLACE OF BURIAL OR REMOVAL: Adel Dallas Co Iowa | ~~DATE OF BURIAL~~ Dec 9 1914

20. UNDERTAKER: D. H. Adair | ADDRESS Payette Ida

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 4
County of Canyon Primary Registration District No. 1008 File No. 1615
City of Payette (No. ....., ... St.) Registered No. 26
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Sarah Anna Loomis.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: July (Month) 24 (Day) 1838 (Year)
7. AGE: 76 yrs. 5 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Virginia
10. NAME OF FATHER: E. Clay.
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Pearl Floyd
(Address) Payette
15.
Filed Dec 18 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. 17 1914
~~Dec~~ (Month) 17 (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw him alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Chronic Nephritis
Uremia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Dec 18 1914
20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

N. B.—Every item of information should be carefully written PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in such a manner that it may be properly classified. Exact statement of OCCUPATION is very important. MARGIN REQUIRED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of CANYON COUNTY
City of PAYETTE IDAHO

Registration District No. 22
Primary Registration District No. 2008
(No. ....., ... St.)

File No. .....
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet A Thacker

If death occurred in a hospital or institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: March 28 (Month) 1827 (Day) (Year)

7. AGE: 87 yrs. 8 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: — Briggs

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chloe Hendren
(Address) Payette, Idaho

15.
Filed Dec 24 1914 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20th 1914, to Dec 22 1914
that I last saw her alive on Dec 22 1914,
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Heart Failure, Senility

(Duration) — yrs. — mos. 10 ds.

Contributory (Secondary)
(Duration) — yrs. — mos. ..... ds.

(Signed) J. E. Crouch M. D.
Dec 24 1914 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Dec 24 1914

20. UNDERTAKER: J. H. Adair — ADDRESS: Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008

File No. 281
Registered No. 102

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Elsworth Dougherty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 19 (Day) 1913 (Year)

7. AGE: 1 yrs. — mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ellis S. Dougherty

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Amanda Carter

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ellis S. Dougherty
(Address) Payette Idaho

15. Filed Dec 30 1914 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26th 1914, to Dec 29th 1914, that I last saw him alive on Dec 29th 1914, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Meningitis

(Duration) — yrs. 2 mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Elmer Crouch M. D.
Dec 30 1914 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: Dec 30 1914

20. UNDERTAKER: Glenn C. Landon
ADDRESS: Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. ....

Registered No. 29

1. PLACE OF DEATH.
County of Canyon
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Cynthia Jane Sherman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 10 (Day) 1841 (Year)

7. AGE: 73 yrs. 5 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Andrew J. Doak

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary Rebecca McConnel

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. A. Sievers
(Address) Payette Idaho

15.
Filed Dec 31 1914 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1914, to Dec. 29 1914
that I last saw her alive on Dec 29 1914
and that death occurred on the date stated above, at 2.30 A.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. N. Avery M. D.
Dec 30 1914 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Dec 31 1914

20. UNDERTAKER: O. H. Adair ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9619
Registered No.

1. PLACE OF DEATH.
County of Nezperce
City of Lapwai

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsa Gladys Johnston

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 27th (Day) 1887 (Year)

7. AGE: 27 yrs. 11 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic Home Wife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Moscow Ida.

10. NAME OF FATHER: Marion Roggers.

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Caroline Geer

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R J Hoskins
(Address) Gifford Ida.

15.
Filed 12-7 1914
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7th 3. A.M. 1914, to Dec 7th 6 P.M. 1914 that I last saw h.r. alive on Dec 7th 1914 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Albuminuria

15 hrs.
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Pulmonary Oedema

15 hrs.
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Herrington M. D.
Dec 7th 1914 (Address) Gifford, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sunnyside
DATE OF BURIAL: 12-8 1914

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
(No. ..... St.)

File No. 1116
Registered No. 126

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milord Hyatt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Dec (Month) 24 (Day) 1914 (Year)
7. AGE ..... Yrs. ..... Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ammon Idaho
10. NAME OF FATHER: Jas. Ross- Hyatt
11. BIRTHPLACE OF FATHER (State or Country): Idaho Falls Ida
12. MAIDEN NAME OF MOTHER: Leona Jurgenson
13. BIRTHPLACE OF MOTHER (State or Country): Idaho -
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Ammon Hyatt. Bonneville Co Idaho
15. Filed Dec 31 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows:

Pneumonia
To Induced Atelectasis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia - Influenza
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. Jurgenson M. D.
12/31 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon Idaho — DATE OF BURIAL: Jan 1st 1915
20. UNDERTAKER: Thos W. Muhlestein — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2107
File No. 1107
Registered No. 121

1. PLACE OF DEATH.
County of Ida Falls
City of Bonneville
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Durond Horatio Calkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Dec (Month) 29 (Day) 1914 (Year)
7. AGE: ~~X~~ Yrs. ~ Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Iona Ida
10. NAME OF FATHER: Vernon H. Calkins
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Olson
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Vern H. Calkins
(Address) Iona, Idaho
15. Filed Dec 30 1914 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 29 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 1914, to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
Im medical attendance
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 11 ds.
(Signed) W. Hammond M. D.
12-30 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iona Ida — DATE OF BURIAL: Dec 31 1914
20. UNDERTAKER: Thos. W. Mickelsen — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9624

Registered No. 124

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2103

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A Eastburg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Dec (Month) 28 (Day) 1840 (Year)

7. AGE 74 Yrs. ... Mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Peterson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER ~~Mary E Johnson~~ ?

13. BIRTHPLACE OF MOTHER ? (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Willie Eastburg
(Address) ...

15. Filed Dec 29 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1914, to Dec 30 1914, that I last saw h[illegible] alive on Dec 27 1914, and that death occured on the date stated above, at 3:30a M.

The CAUSE OF DEATH* was as follows:

Acute Mania

(Duration) ... Yrs. 1 mos. ... ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) ... yrs. 1 mos. ... ds.

(Signed) [signature] M. D.

(Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?...
Former or usual residence ...

19. PLACE OF BURIAL OR ~~REMOVAL~~ Idaho Falls — DATE OF BURIAL 12/30 1914

20. UNDERTAKER C C Dunwoody — ADDRESS Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2 [illegible]
File No. 111
Registered No. 123

1. PLACE OF DEATH.
County of Bonneville
City of Iona
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lola N. Russell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Oct (Month) 13 (Day) 1914 (Year)

7. AGE: X Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... X
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iona, Ida

10. NAME OF FATHER H. A. Russell

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Treasure Russell

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. A. Russell
(Address) Iona, Ida

15. Filed Dec 22 1914 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occured on the date stated above, at 8:15a M.

The CAUSE OF DEATH* was as follows:

Pneumonia
No Medical attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
12/22 1914 (Address) Iona Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Iona, Ida — DATE OF BURIAL: 12/22 1914

20. UNDERTAKER: [illegible] — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 12, 02
(No. ....., ... St.)

File No. 1121
Registered No. 122

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.) Married

6. DATE OF BIRTH. Jan (Month) 6 (Day) 1832 (Year)

7. AGE: 82 Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Delaware

10. NAME OF FATHER: Adams

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Adams
(Address) Idaho Falls

15.
Filed Dec 19 191 4
C C Hansen
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 25 1914, to Dec 18 1914, that I last saw h[e] alive on Dec 18 1914, and that death occured on the date stated above, 2-35A M.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia
Contributory
(Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C C Hansen M. D.
12/19 1914 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill
DATE OF BURIAL: Dec 21 1914

20. UNDERTAKER: J H Hunt
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville

City of Ucon

Registration District No. 72

Primary Registration District No. 2 4 7 3

(No. ....., ... St.)

File No. 1174

Registered No. 1271

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James G Godfrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 23 (Day) 1873 (Year)

7. AGE: 41 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer): and Milling

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Godfrey

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sophia Clifton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Godfrey By E E H

(Address) Ucon Ida

15. Filed Jan 17 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6th 1914, to Dec 14 1914, that I last saw him alive on Dec 14 1914, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.

12 1914 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ucon Ida — DATE OF BURIAL: 1/17/1914

20. UNDERTAKER: E E Dinwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 10
(No. ....., ... St.)

File No. 1113
Registered No. 114

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls

2. FULL NAME Wm R King

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 20 (Month) June (Day) 1891 (Year)

7. AGE: 73 Yrs. 5 Mos. 12 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm H King

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha S Russel

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. King
(Address) Iona, Ida

15.
Filed Dec 5 1914
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1914, to Dec. 2, 1914, that I last saw him alive on Dec. 2, 1914 and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia
.....
.....
(Duration) ..... Yrs. ..... mos. .....
Contributory (Secondary) Relapse
(Duration) ..... yrs. ..... mos. 3 ds.
(Signed) John C Mullen M. D.
12/5 1914 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iona, Ida
DATE OF BURIAL: 12/5 1914

20. UNDERTAKER: E E Dinwoodey
ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 2007

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10.5

Registered No. 70

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell farm

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Boughton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1828 (Year)

7. AGE: 86 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Dont Know

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): — —

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. C. Pearson

(Address) Caldwell Idaho

15. Filed 12-25- 1914

John D. Keyes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1914, to Dec 4 1914, that I last saw h[illegible] alive on Dec 3 1914, and that death occured on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Cole M. D.

12-25- 1914 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 12-26- 1914

20. UNDERTAKER: W. L. Dyer — ADDRESS: Caldwell Ida

BYRD - YORK CO., PTRS. & BOOKS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Caldwell (No. ....., ... St.)
File No. 141
Registered No. 71

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Baby Dement.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1914 (Year)

7. AGE: ... yrs. ... mos. ... ds. IF LESS than 1 day how many ½ hrs. or ... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Caldwell Idaho.

10. NAME OF FATHER: James A. Dement Jr.

11. BIRTHPLACE OF FATHER (State or Country): Caldwell Idaho.

12. MAIDEN NAME OF MOTHER: Helen Humphries.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James A. Dement Jr.
(Address) Caldwell, Idaho.

15. Filed 12-15- 1914. Jas. S. Dwyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1914, to Dec 15 1914 that I last saw him alive on Dec 15 1914 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth.

..... (Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Allen Greenway M. D.
Dec 15 1914 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cemetery. DATE OF BURIAL: Dec 15 1914

20. UNDERTAKER: Beckham Case Co. ADDRESS: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

File No. 101

Registered No. 72

County of Canyon

City of Greenleaf

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Faris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 15 (Day) 1914 (Year)

7. AGE: .....Yrs. .....Mos. 4 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm Faris

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER Florence Robinson

13. BIRTHPLACE OF MOTHER (State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A A Faris

(Address) Caldwell Idaho

15. Filed 12-31-1914

John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1914, to Dec 18 1914, that I last saw him alive on Dec 17 1914 and that death occured on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:

Dranation

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) S. D. Mills M. D.

Dec 31-1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge — DATE OF BURIAL: Dec 20 1914

20. UNDERTAKER: Relatives — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 10.1
Registered No. 73

1. PLACE OF DEATH.
County of Canyon
City of Greenleaf
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Faris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 15 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. H ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm Faris

11. BIRTHPLACE OF FATHER (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Florence Robinson ~~Faris~~

13. BIRTHPLACE OF MOTHER (State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A A Faris
(Address) Caldwell Ind

15. Filed 12-31-1914 Jos. L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1914, to Dec 18 1914, that I last saw him alive on Dec 17 1914, and that death occured on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:
Spasm
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) S J Mullen M. D.
Dec 31 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge — DATE OF BURIAL: Dec 20 1914
20. UNDERTAKER: Relatives — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

3VMB - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-2[illegible] M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 111.3
Registered No. 74

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Gabels Atkin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 10X (Day) 1851 (Year)

7. AGE: 63 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Rauk Atkin

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs T W Rice
(Address) Caldwell Ida

15. Filed Dec. 21 1914
Local Registrar: J. W. Meyer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20 1914, to Dec. 20 1914, that I last saw him alive on Dec. 20 1914, and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Bitter Disease.

(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary): Hemorrhage from Lungs
(Duration ..... yrs. ..... mos. 10 ds.

(Signed) J. M. Henry M. D.
12-21-1914 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Dec 21 1914

20. UNDERTAKER: W C Dyer — ADDRESS: Caldwell

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 111.

Registered No. 75

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 7005

County of Canyon

City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel Christine Dickson.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH. Feb. (Month) 6 (Day) 1845 (Year)

7. AGE: 59 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Solomon Burk.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Mary Hoskinson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle Markwick.

(Address) Deer Park Wash.

15. Filed 12-28- 1914

John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1914, to Dec 26 1914, that I last saw her alive on Dec 26 1914, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Coma

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

12/27 1914 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 12/28 1914

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell. Ida.

SYMS - YORK CO., PTRS. & BOOK. 24858

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 9636

Name Rachel Dickson

Date of Death 12-26-14

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) J. M. Lee M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. Dr Howard

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock — Registration District No. 84 — File No. 6111

City of Pocatello — Primary Registration District No. 246 — Registered No. 260

(No. Gen. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Damaskopoulos

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Exact date unknown (Month) (Day) 1874 (Year)

7. AGE 40 Yrs. ... Mos. ... ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... R R Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Greece

10. NAME OF FATHER Harry Damaskopoulos

11. BIRTHPLACE OF FATHER (State or Country) Greece

12. MAIDEN NAME OF MOTHER Martha Meaceres

13. BIRTHPLACE OF MOTHER (State or Country) Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Contes
(Address) [illegible]

15. Filed Nov 27, 1914 — [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26 1914, to Dec. 1 1914, that I last saw him alive on Dec. 1 1914, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Hepatitis
(Duration) — Yrs. Few mos. — ds.
Contributory (Secondary) Abscess Lung
(Duration — yrs. One mos. — ds.
(Signed) W J Howard M. D.
12/2 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death One yrs. ... mos. One days. In the Pocatello State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? Pocatello
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View	Dec 3 1914
20. UNDERTAKER	ADDRESS
Crawford and Shumaker	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

Newton M.D.

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

(No. 217 N. Garfield St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6

Registered No. 241

1. PLACE OF DEATH.

County of Bannock

City of Pocatello Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of Belmont

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Greek

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 11 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ogden Utah

10. NAME OF FATHER Mathew Balmont

11. BIRTHPLACE OF FATHER (State or Country) Greece

12. MAIDEN NAME OF MOTHER Mary Brown

13. BIRTHPLACE OF MOTHER (State or Country) Arizona

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathio Balmont

(Address) Pocatello Idaho

15. Filed Dec 4 1914 O. F. Bleecker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3rd 1914, to Dec 4 1914, that I last saw h[illegible] alive on Dec 4 1914, and that death occured on the date stated above, at 1. A. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Malnutrition

(Duration ..... yrs. ..... mos. 14 ds.

(Signed) C. M. Newton M. D.

Dec 19 14 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pocatello Cemetery — DATE OF BURIAL Dec 5 1914

20. UNDERTAKER Wallace & Sons — ADDRESS Pocatello Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. 352, South 3rd Ave. St.)

File No. 9639
Registered No. 262

1. PLACE OF DEATH.
County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Marie Dwassing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 16 (Day) 1914 (Year)

7. AGE: Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Carl Dwassing

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Edith Dodson

13. BIRTHPLACE OF MOTHER (State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Pocatello.

15. Filed Dec 10 1914 — J. J. Finch, Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH 9639

16. DATE OF DEATH
Dec (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1914, to Dec 10 1914, that I last saw h.w alive on Dec 9 1914, and that death occured on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Acute enteritis

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Acute Bronchitis
(Duration ..... yrs. ..... mos. 2 ds.

(Signed) A. M. Merton M. D.
Dec 10 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Wallace & Sons — ADDRESS: Pocatello, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. ....., Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161

File No. 6
Registered No. 263
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander Belak

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	Hungarian	

6. DATE OF BIRTH: Feb (Month) 29 (Day) 1880 (Year)

7. AGE: 34 yrs. 9 mos. 10 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hungary

10. NAME OF FATHER: Steve Belak

11. BIRTHPLACE OF FATHER (State or Country): Hungary

12. MAIDEN NAME OF MOTHER: Jadiana Junkune

13. BIRTHPLACE OF MOTHER (State or Country): Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Steve Belak
(Address) Pocatello, Idaho.

15. Filed Dec 19 1914 — Dec 19 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1914 to Dec 19 1914, that I last saw h. in alive on Dec 18 1914, and that death occurred on the date stated above, at 1:15 M.

The CAUSE OF DEATH* was as follows:
Acute nephritis

(Duration) yrs. 2 mos. 10 ds.
Contributory (Secondary) Chronic bronchitis
(Duration) 2 yrs. mos. ds.

(Signed) A. M. Newton M. D.
Dec 19 1914 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Dec 20 1914

20. UNDERTAKER: Wallace & Wann — ADDRESS: Pocatello, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. Ken, Dr Hospital St.)

File No. 6 1144
Registered No. 265
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wallace D. Cracken

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Virginia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Dec 10 1914 O B Spring
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914, to Dec 8 1914, that I last saw him alive on Dec 8 1914, and that death occurred on the date stated above, at 5:35 M.

The CAUSE OF DEATH* was as follows:
Uraemia
(Duration) yrs. mos. 3 ds.
Contributory (Secondary) Alcoholism Ant.
(Duration) yrs. mos. 10 ds.
(Signed) Wm. Newton M. D.
19 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Madison, Ohio
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Wallace & Wann
ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6

Registered No. 266

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. 156, North 3rd ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Winter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Apr (Month) 20 (Day) 1853 (Year)

7. AGE

60 yrs. 9 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Supt. Water Co.

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alex Murray

(Address) Pocatello, Idaho

15.

Filed Dec 11, 1914 O B Sims Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8th 1914, to Dec 9 1914, that I last saw h[illegible] alive on Dec 9 1914, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Smith Dawson M. D.

Dec 10 1914 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Denver Colo. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Wallace & Dann ADDRESS: Pocatello, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 6
Registered No. 267
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Tsebaris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Greek	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
22 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Greece

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country) 12

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Dec 13, 1914 O B Seely Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12th 1914, to Dec 12th 1914, that I last saw h— alive on ..... 191..., and that death occurred on the date stated above, at 7.00 M.

The CAUSE OF DEATH* was as follows:
Homicide
Shooting
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O B Seely Coroner M. D.
12-13- 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City Utah	..... 191...

20. UNDERTAKER	ADDRESS
Wallace & Mann	Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 6/9645
Registered No. 268

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. Gen Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Henry Albert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct 16 (Month) (Day) 1857 (Year)

7. AGE: 57 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Cattle Man

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Josiah Albert

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Elizabeth Haney

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs E. H. Albert
(Address) American Falls

15. Filed Dec 19, 1914
O. P. Steely
Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 18 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10 1914 to Dec. 18 1914 that I last saw him alive on Dec. 17 1914 and that death occured on the date stated above, at 1:30 A. M.

THE CAUSE OF DEATH* was as follows:
Hypertrophy due to Cancer Liver
Late diagnosis, exploration, Expanding
(Duration) One Yrs. mos. ds.
Contributory (Secondary) Carcinoma Liver
(Duration One yrs. mos. ds.
(Signed) H. F. Howard M. D.
12/19/1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 28 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Idaho
Former or usual residence Texas

19. PLACE OF BURIAL OR REMOVAL: American Falls
DATE OF BURIAL: Dec 20 1914

20. UNDERTAKER: Gay Ford and Schumacher
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

(No. 227, South Hayes St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6 1114

Registered No. 269

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans P. Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept. (Month) 24 (Day) 1850 (Year)

7. AGE: 64 yrs. 3 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Larson Hanson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Kat Knudson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie Hansen
Pocatello

(Address)

15. Filed Dec 23 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 – 1914, to Dec 22 – 1914, that I last saw him alive on Dec 22 – 1914, and that death occurred on the date stated above, at 2.55 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O P Stevens M. D.

12-22 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Dec 27 1914

20. UNDERTAKER: Wallace & Wann — ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 9646

Name Hans L. Hanson

Date of Death 12-28-14

Cause of Death Lobar Pneumonia

Contributary Cause of death none

(Sign here) O B Keeley M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 6111
Registered No. 270

1. PLACE OF DEATH.
County of Bannock
City of Pocatello.
(No. 310 3rd ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Antonio Samora
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. November 21 (Month) (Day) 1914 (Year)

7. AGE: — Yrs. 1 Mos. 2 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bannock Co.

10. NAME OF FATHER: John Samora

11. BIRTHPLACE OF FATHER (State or Country): New Mexico

12. MAIDEN NAME OF MOTHER: Alexandria Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): New Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Samora
(Address)

15. Filed Dec 24 1914 Dec 24 1914
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23rd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1914, to Dec 23 1914, that I last saw him alive on Dec 23 1914 and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Malnutrition
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Impoverished milk
(Duration yrs. mos. ds.
(Signed) [illegible] M. D.
Dec 24 1914 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Dec 24 1914

20. UNDERTAKER: Wallace & Wann — ADDRESS: Pocatello, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 6114
Registered No. 271

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Ben Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matheus Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Dec 27 1914 — O B Dicey, Local Registrar

Suicidal Intoxication to obtain

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1914, to Dec 26 1914, that I last saw h. in alive on Dec 26 1914, and that death occured on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:
Phenol Poisoning
Suicidal

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O B A M. Newton M. D.
Dec 27 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence ..... California

19. PLACE OF BURIAL OR REMOVAL: Denver, Colo. — DATE OF BURIAL: 12-29 1914

20. UNDERTAKER: Wallace & Mann — ADDRESS: Pocatello

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1146

Registered No. 272

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. Gen Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. B. Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... 1 (Month) (Day) (Year)

7. AGE: 13 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Baxter

(Address) Challis Idaho

15. Filed Dec 30th 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11" 1914, to Dec. 28" 1914, that I last saw him alive on Dec. 28" 1914, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. mos. 19 ds.

Contributory (Secondary) 2nd ary Infection

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) F. M. Glasgow M. D.

12-29 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Pocatello Ida.

Former or usual residence Challis Ida.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Dec 29 1914

20. UNDERTAKER: Wallace & Sons. — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 2161

File No. .....

Registered No. 248

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. Gen Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George M Waite

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May 20 1895
(Month) (Day) (Year)

7. AGE: 19 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Levi Waite

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Mickelson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hannah Lundgren
(Address) Rockland Idaho

15. Filed Nov 6th 1914 O. J. Hess Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1914 to Nov. 5 1914, that I last saw him alive on Nov. 5 1914 and that death occured on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:—
Purulent Peritonitis following rupture of appendiceal abscess

(Duration) — Yrs. One mos. — ds.

Contributory (Secondary): .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) W. F. Howard M. D.

11/6/1914 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? Rockland Idaho
Former or usual residence Rockland Idaho

19. PLACE OF BURIAL OR REMOVAL: American Falls Idaho. DATE OF BURIAL: 11/6 1914

20. UNDERTAKER: Wallace & Hawes ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. Stiely

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2164
File No. 6
Registered No. 249

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Gunsmoke apt St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Reese N Coleman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: 1

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov (Month) 7 (Day) 1914 (Year)

7. AGE: ....Yrs. 5 Mos. ....ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Thomas W Coleman

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Erma E Reese

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos. W. Coleman
(Address) Gunsmoke apt.

15. Filed Nov 13 1914 O J Stiely Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191...., to Nov 12 1914, that I last saw him alive on Nov 12 1914 and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Hepatitis (acute)

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....

....(Duration ....yrs. ....mos. ....ds.

(Signed) O J Stiely M. D.
11-12-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Nov 13 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS: City

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6

Registered No. 250

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 637 W Lewis St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John R McFadden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 16 (Day) 1914 (Year)

7. AGE: ....Yrs. ....Mos. 1 8 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carl L. McFadden

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mabel Vincent

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl L McFadden

(Address) Pocatello, Idaho

15. Filed Nov 13 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1914, to Nov 12 1914, that I last saw him alive on Nov 12 1914, and that death occured on the date stated above, at 3-39 M.

The CAUSE OF DEATH* was as follows:

Malnutrition

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) .....M. D.

Nov 13 1914 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary | DATE OF BURIAL: Nov 13 1914

20. UNDERTAKER: Wallace & Wann | ADDRESS: Pocatello, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Newton M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 6 111
Registered No. 251

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 341, S. 6th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of Lewis M. Harvey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 13 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lewis M. Harvey

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Elizbeth F. Hess

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lewis M. Harvey.
(Address) Pocatello.

15. Filed Nov 14 1914 — O. B. Lindsley, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 AM 1914, to Nov 13 PM 1914, that I last saw him alive on Nov 13 1914, and that death occured on the date stated above, at 5:30 P M.

The CAUSE OF DEATH* was as follows:
Thymic asthma. or enlarged thymus gland

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A M Newton M. D.
Nov 14 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 1914

20. UNDERTAKER: Wallace & Sons — ADDRESS: Pocatello

SYMS - YORK CO., PTRS. & SDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 54
Primary Registration District No. 2161
File No. 9654
Registered No. 252

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Mineral Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Frances McConkey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1851 (Year)

7. AGE: 63 Yrs. 9 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thos. Graves

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Wright

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Effie Kroll
(Address) Pocatello Ida.

15. Filed Nov 16 1914 O F Steers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9 1914, to Nov. 16 1914, that I last saw her alive on Nov. 16 1914, and that death occured on the date stated above, at 6 00 a M.

The CAUSE OF DEATH* was as follows:
Carcinoma cervix uteri
(Duration) Yrs. 6 mos. 7 ds.
Contributory (Secondary) Postoperative Peritonitis
(Duration) Yrs. mos. 5 ds.
(Signed) W. J. Howard M. D.
Nov 16 1914 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. 8 days.
Where was disease contracted if not at place of death? At home
Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary
DATE OF BURIAL ..... 191.....

20. UNDERTAKER: Wallace & Wann
ADDRESS Pocatello, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6

Registered No. 253

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. 2 S 1st ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tressa A. Patton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 20 (Day) 1865 (Year)

7. AGE: 48 Yrs. 10 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a). Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York N Y

10. NAME OF FATHER: Philip Coffey

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Patton

(Address) James Patton 2 St 1st ave

15. Filed 11/17/14 191....

O. P. Hoely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1914, to Nov 10 1914, that I last saw her alive on Nov 10 1914 and that ~~death occured on the date stated above~~, at ..... M.

The CAUSE OF DEATH* was as follows: Did not see her on day of death.

Cause Death: Tuberculosis of the Lungs.

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary): None

(Duration — yrs. — mos. — ds.

(Signed) H. A. Castle M. D.

Nov 17 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oxtell Kansas — DATE OF BURIAL: Nov 20 1914

20. UNDERTAKER: Crawford & Schumacher — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 6956
Registered No. 254

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ..... 2nd Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Nov 17, 1914 — [illegible] Local Registrar

Unable to obtain information

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1914, to Nov 16 1914, that I last saw her alive on Nov 16 1914 and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Opium poisoning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
19.... (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Dec 4 1914

20. UNDERTAKER: Wallace & Mann — ADDRESS: Pocatello, Idah

BYNG - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1116
Registered No. 255

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(No. 1034 N. Gaisford St.)

Registration District No. 84
Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth P. McWherter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. March 27 (Month) (Day) 1912 (Year)
7. AGE: 1 Yrs. 7 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Edwin McWherter
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Elizabeth Clark
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Pugmire
(Address) Pocatello
15. Filed Nov 19 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Nov 18 (Month) (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1914, to Nov 18 1914, that I last saw h[illegible] alive on Nov 17 1914 and that death occured on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Cystitis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
Nov 19 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Nov 22 1914
20. UNDERTAKER: Crawford and Schumacher — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24855

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 6
Registered No. 256

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude Eugene Dumas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
Oct (Month) 25 (Day) 1913 (Year)

7. AGE
.....Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) New

10. NAME OF FATHER Edward J. Dumas

11. BIRTHPLACE OF FATHER
(State or Country) Vt.

12. MAIDEN NAME OF MOTHER Queen V. Grow

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Queen Dumas
(Address) Pocatello, Idaho

15. Filed Nov 21, 1914
O. B. Stacy
Local Registrar

BYNS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20th 1914, to Nov 20th 1914, that I last saw h.s.m. alive on Nov 20th 1914, and that death occured on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:
Spasmodic Croup

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) H. A. Cassity M. D.
Nov 21 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ogden Utah	.....191....
20. UNDERTAKER	**ADDRESS**
Wallace & Mann	Pocatello, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6111

Registered No. 257

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 441 E. Hayden St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Gregoire

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 10th (Month) 11 (Day) 1852 (Year)

7. AGE: 62 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Night watchman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Car shop O.S.L.

9. BIRTHPLACE (State or Country) Mass

10. NAME OF FATHER Thomas Gregoire

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Sophia Dupery

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Gregoire

(Address) 441 E. Hayden St.

15. Filed Nov 30, 1914 — O P Lucy, Local Registrar

BYRNE - YORK CO., PTRS. & BKRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 – 1914, to Nov 29th 1914, that I last saw him alive on Nov 25 – 1914 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O P Lucy M. D.

Nov 30 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Dec 2 1914

20. UNDERTAKER: Crawford and Schumacher — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 6
Registered No. 2318

1. PLACE OF DEATH.
County of Bannock
City of Alexander (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Possibly Walter Carnes) Unknown
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 ..... (Year)

7. AGE 30 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... /
(b) General nature of industry, business, or establishment in which employed (or employer)... Laborer

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Nov 30 1914 O.P. Stucy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
About Nov (Month) 25 (Day), 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gunshot wound
Homicide
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) O.P. Stucy Coroner M. D.
11-30-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho
DATE OF BURIAL: Nov 29 1914

20. UNDERTAKER: Wm Rudeman
ADDRESS: Pocatello, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

Newton M.D.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 6 1101
Registered No. 259

1. PLACE OF DEATH.
County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Albertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Sept. (Month) 18 (Day) 1844 (Year)

7. AGE: 70 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Andrew Albertson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albertus Jensen
(Address) Shelley Idaho

15. Filed Nov 29 1914
Dec 1. O. B. Steel
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1914, to Nov 28 1914, that I last saw h. alive on Nov 27 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Sepsis from pyonephrosis and Cystitis

(Duration) Yrs. 2 mos. ..... ds.
Contributory (Secondary) Senility.
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Newton M. D.
Nov 30 1914 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: Nov 30 1914

20. UNDERTAKER: Wallace & Sons. — ADDRESS: Pocatello, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should carefully supply all item of information. AGE should be stated EXACTLY. If death occurs away from usual residence, give facts called for under special information. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123

County of Shoshone

Primary Registration District No. 1201

File No. 31

City of Kellogg (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME X John James Lent

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: X July (Month) 22 (Day) 1838 (Year)

7. AGE: X 76 yrs. 3 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Livingston Co. N.Y.

10. NAME OF FATHER X James S Lent

11. BIRTHPLACE OF FATHER X (State or Country)

12. MAIDEN NAME OF MOTHER X Annie Jennings

13. BIRTHPLACE OF MOTHER X (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Fred N Lent
(Address) Wardner Idaho

Filed 1 Nov 1914 Geo. A Leeber, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1912 to Nov. 1914, that I last saw h.m alive on Oct 1914 and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:
Enlargement of prostate
Cystitis, pyelitis - old age

(Duration) 3 yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. [illegible] M. D.

Dec 14 1914 (Address) Kellogg, Ida Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho — DATE OF BURIAL: Nov 22, 1914

20. UNDERTAKER: M C Thornbrue — ADDRESS: Kellogg Ida

BYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. ....

Registered No. ....

Registration District No. ....

Primary Registration District No. ....

(No. ...., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Kellogg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nazereth Mahew

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Feb (Month) 28 (Day) 1842 (Year)

7. AGE: 72 Yrs. 9 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter (Ship)

(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: no information

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: no information

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nazereth Mahew

(Address) Kellogg Idaho

15. Filed 12/22 1914 Geo. S. Lesher Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1914, to Dec 20 1914, that I last saw him alive on Dec 19 1914, and that death occured on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

(a) Arteria Sclerosis complicated by old age

(Duration) .... Yrs. 1 mos. .... ds.

Contributory (Secondary) ....

(Duration .... yrs. .... mos. .... ds.

(Signed) H. C. Lindsley M. D.

12/20/ 1914 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, -Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Dec 22 1914

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 1101
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mike Slevitt

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
50 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country): no information

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER
(State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER
(State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E B Shanklin
(Address) Kellogg, Idaho

15.
Filed 12/22 1914 Geo. D Lesher.
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Acute alcoholism - died before medical attention was obtained.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alex M. McCracken M. D.
Dec 22 1914 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho — DATE OF BURIAL: aug 24 1914

20. UNDERTAKER: E B Shanklin — ADDRESS: Kellogg Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of .....

Registration District No. 70

Primary Registration District No. 1041

(No. ....., ... St.)

File No. 1016

Registered No. 84

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov. 23 (Month) (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Harry Langell

11. BIRTHPLACE OF FATHER (State or Country) Nova Scotia

12. MAIDEN NAME OF MOTHER Gertrude Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Linn. Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Langell

(Address) .....

15. Filed Nov 24 1914 H. LeRoy Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH NOV 24 1914 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/20/14 191, to 11/24/14 191, that I last saw h alive on 11/24/14 191, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH was as follows: Pernicious Anemia - 5 ½ months

.....

.....

.....

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) 2 yrs 11 mos. ..... ds.

(Signed) Thomas E. Jones, M. D.

11/24/1914 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace — DATE OF BURIAL Nov 24 1914

20. UNDERTAKER Wards Undertaking Co — ADDRESS Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Shoshone
City of Wallace (No. ....., ... St.)
Registration District No. 70
Primary Registration District No. 011
File No. .....
Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ricardo Vincent V.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 35 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Astley Worcestershire England

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. Thompson
(Address) Wallace Ida

15. Filed Nov 21 1914 F. L. Lemley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 — 1914, to Nov 19 1914, that I last saw him alive on Nov 19 1914, and that death occured on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Struck by falling tree
Broken Skull and all
Ribs on right side Crushed in

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. L. Jones M. D.
19..... (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: [redacted] 21 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

BYRNE - YORK CO., PTRS. & BDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital St.)

File No. 1111
Registered No. 82
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Roy Kuig

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
1 (Month) (Day) (Year)

7. AGE: 27 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Thomas Kuig

11. BIRTHPLACE OF FATHER (State or Country): Not given

12. MAIDEN NAME OF MOTHER: a y

13. BIRTHPLACE OF MOTHER (State or Country): a e

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. L. Freeman
(Address) Wace Idaho

15.
Filed Nov 21 1914
F. Leo Sunday
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 17 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 1914, to Nov 17 1914
that I last saw h-m alive on Nov 17, 1914,
and that death occurred on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) yrs. mos. 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Nov 17 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Galena Kansas
DATE OF BURIAL: Nov 21 1914

20. UNDERTAKER: Bruce Morrison
ADDRESS: Wallace Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5, 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 10 11
(No. Cor Bank & Ruig Sts.)

File No. 11
Registered No. 81
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Rose Elizabeth Lamielle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Aug (Month) 12 (Day) 1848 (Year)

7. AGE: 66 yrs. 2 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Julius Pukker

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Lamielle
(Address) Kellogg Idaho

15. Filed Nov 11 1914 F Leo Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 8 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1914, to Nov 8 1914, that I last saw her alive on Nov 8 1914 and that death occurred on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) yrs. 8 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr Mowery M. D.
Nov 9 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Wisconsin
DATE OF BURIAL: Nov 12 1914

20. UNDERTAKER: Bruce G Mostell
ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 6061
File No. 1116
Registered No. 80

1. PLACE OF DEATH
County of Shoshone
City of Wallace
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary N. Bright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Wallace

10. NAME OF FATHER: E. S. Bright

11. BIRTHPLACE OF FATHER
(State or Country) Colorado

12. MAIDEN NAME OF MOTHER: Elsie Middleton

13. BIRTHPLACE OF MOTHER
(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. S. Bright
(Address) Wallace Idaho

15.
Filed Nov 10 1914 F. Leo Lindley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8th 1914, to Nov 10th 1914, that I last saw h[illegible] alive on Nov 10 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Malnutrition
.....
.....
(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
11.10.1914 (Address) [signature]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace. DATE OF BURIAL: Nov 11, 1914

20. UNDERTAKER: Ward Undertaking Co ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOLS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 1011
(No. Providence Hospital St.)

File No. [illegible]
Registered No. 579
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Espie Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Apr (Month) 15th (Day) 1877 (Year)

7. AGE: 37 yrs. 5 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: telegrapher
(b) General nature of industry business or establishment in which employed (or employer): Railway service

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Robert Anderson

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Eliza Lake

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Lowe
(Address) Calgary

15. Filed Nov 8 1914 F Leo Dingy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Oct~~ Nov (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1914, to Nov 6 1914, that I last saw him alive on Nov 6 1914, and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D Mooney M. D.
Nov 8 1914 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Belleville Ontario
DATE OF BURIAL: Nov 9th 1914

20. UNDERTAKER: Bruce G Worstell
ADDRESS: Wallace Ida

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 111
Registered No. 18

1. PLACE OF DEATH
County of Shoshone
City of Wallace (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest Berg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov 5th 1914
(Month) (Day) (Year)
1 da

7. AGE: ....Yrs....Mos....1....ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wallace

10. NAME OF FATHER: Edward Berg

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Helen Matthey

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Berg
(Address) Wallace Ida

15. Filed Nov 7 1914 F Leo Zingle
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Nov 6 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1914, to Nov 6 1914, that I last saw h.sm alive on Nov 5 1914 and that death occured on the date stated above, at 9a.m.

The CAUSE OF DEATH* was as follows:†
Premature birth
(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration) 1 hr Yrs....mos....ds.

(Signed) D.S. Mowry M.D.
Nov 6 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Nov 7th 1914

20. UNDERTAKER: Ward Undertaking Co — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur d'Alene (No. ....., ... St.)
File No. 1113

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Harry Philips

Registered No. 12

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Nov. (Month) 13 (Day) 1913 (Year)

7. AGE: ..... yrs. 11 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Harry Philips

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Britta Fry

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Harry Phillips
(Address) 1115 E Coeur d'Alene

15. Filed Nov. 7 1914 Mark Soland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 6th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th 1914, to Nov 6th 1914 that I last saw h[illegible] alive on Nov 6th 1914 and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:
Failure of digestion and assimilation

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Osteopath - L. H. Mast
Nov 6 1914 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Nov. 8 1914

20. UNDERTAKER: Cascade Nelson — ADDRESS: 209-2nd

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3101

Registered No. 11

1. PLACE OF DEATH. Registration District No. 29

County of Kootenai Primary Registration District No. 1050

City of Coeur D'Alene (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Swanson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 17 (Day) 1849 (Year)

7. AGE: 65 yrs. 2 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Sven Swenson

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Johnson
(Address) Coeur D'Alene

15. Filed Nov 7 1914 Max C. Graves Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 4th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1912, to Nov 1914 that I last saw h[illegible] alive on Nov 4 1914 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
and emphysema

..... (Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Busby M. D.

Nov 6 1914 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.

In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: Nov 8 1914

UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3111
Registered No. 10

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucia A. Bartlett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widowed

6. DATE OF BIRTH: 6 (Month) 6 (Day) 1841 (Year)

7. AGE: 73 yrs. 5 mos. 1 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Jas. Perry

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Elizabeth Ward

13. BIRTHPLACE OF MOTHER (State or Country): Canada,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lora M Bell
(Address)

15. Filed Nov. 7 1914 Mark L. Sheard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4 1914, to Nov 7 1914 that I last saw h— alive on Nov 4 1914 and that death occurred on the date stated above, at 1:20 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 7 yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) M J Holden M. D.

Nov 7 1914 (Address) Coeur D'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hope Cemetary — DATE OF BURIAL: Nov. 8 1914

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 111
Registered No. 9

1. PLACE OF DEATH. Registration District No. 29
County of Spokane Primary Registration District No. 1050
City of Spokane Bridge (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Mrs Emma Cryderman
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: August (Month) 17 (Day) 1832 (Year)
7. AGE: 82 yrs. 2 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: Jacob Pillar
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Cryderman
(Address) Post Falls Ida
15. Filed Nov. 8 1914 M S Ward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 8 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Nov 8 1914
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Complications of Lagrape
..... (Duration) — yrs. — mos. 8 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Myers M. D.
11/9 1914 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant view Cem. DATE OF BURIAL: Nov 9 1914
20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 311
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Horace Harrington

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX. Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH June 4th (Month) (Day) 1844 (Year)

7. AGE 70 yrs. 4 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Court Bailiff
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Orona Maine

10. NAME OF FATHER Charles Harrington

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Hannah Drew

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Cook
(Address) 719 N. 7th St Coeur d'Alene

15. Filed Nov 2 1914 M. McDonald Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH November 2nd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1912, to Nov 2 1914 that I last saw h[illegible] alive on Nov 2nd 1914 and that death occurred on the date stated above, at 8 9 M.

The CAUSE OF DEATH* was as follows:
1 Cardiac insufficiency

..... (Duration) 3 yrs. — mos. — ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunby M. D.
Nov 5 1914 (Address) Coeur D'alene Idy

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Forest Cemetary — DATE OF BURIAL Nov 5 1914

20. UNDERTAKER Cassedy & Nelson — ADDRESS Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 91

Registered No. 14

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

County of Kootenai

City of Coeur d Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Moses Fredenburg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1840 (Year)

7. AGE 74 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New Jersey

10. NAME OF FATHER - Fredenburg

11. BIRTHPLACE OF FATHER (State or Country) New Jersy

12. MAIDEN NAME OF MOTHER Emily Warner

13. BIRTHPLACE OF MOTHER (State or Country) N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer Fredenburg

(Address) Coeur d Alene

15. Filed Nov. 25 1914 W. M. Rolland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1913, to Nov 24 1914, that I last saw him alive on Nov 24 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Arthrio Sclerosis

..... (Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Dwyer M. D.

Nov 25 1914 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	Nov 27 1914
20. UNDERTAKER	**ADDRESS**
O J Lee	C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SOBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29.

Primary Registration District No. 1036

File No. 1879

County of Kootenai

City of Coeur d'Alene (No. .... St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mamie Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1869 (Year)

7. AGE: 45 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ferdinan Fritz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Nov 27 1914 M. E. Soward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1910, to Nov 27 1914, that I last saw her alive on Nov 12 1914, and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

General carcinomatosis.

Primary in breast

..... (Duration) 9 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) John Hunt Shepherd M. D.

19 ..... (Address) Coeur d'alene Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Lawn — DATE OF BURIAL: Nov 29 1914

20. UNDERTAKER: D. J. Green — ADDRESS: C D A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 1117
Registered No. 16

1. PLACE OF DEATH, Registration District No. 29
County of Kootenai Primary Registration District No. 1058
City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pierre McConville

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: 9 (Month) 16 (Day) 1837 (Year)

7. AGE: 77 yrs. 2 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired ship
(b) General nature of industry business or establishment in which employed (or employer): broker.

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Jas. McConville

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary - - -

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,
(Informant) Clara E. McConville
(Address) 750 Government Way

15. Filed Nov 29 1914 W. A. Sloan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5 1914, to Nov. 27 1914, that I last saw h im alive on Nov. 27 1914 and that death occurred on the date stated above, at 11¼ A.M.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis.

(Duration) 1 yrs. 6 mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Myers M. D.
Nov 27 1914 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Nov. 29 1914

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3116
Registered No. 17

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Holmberg

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Peter Holmberg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Borle

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anton Olsen
(Address) .....

15. Filed Nov 21 1914 Mark S. Boland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 21st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1912, to Nov 21 1914
that I last saw him alive on Nov 21 1914
and that death occurred on the date stated above, at 6 9 M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the Lungs

..... (Duration) 6 yrs. — mos. — ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunby M. D.
Nov 21 1914 (Address) Coeur d'alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 11-22 1914

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: 209-2nd

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D' Alene

Registration District No. 105-0
Primary Registration District No. 29
(No. ....., ... St.)

File No. 3
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Cross

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan. (Month) 7 (Day) 1837 (Year)

7. AGE: 77 yrs. 10 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veterinary Surgeon
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Cross

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah E. Cross
(Address) .....

15. Filed Nov 17 1914 Wade Talbot Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 12th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12th 1914, to Nov 12th 1914 that I last saw him alive on Nov 12th 1914 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy -

..... (Duration) ..... yrs. ..... mos. 3 hrs. ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. Bunby M. D.

Nov. 17th 1914 (Address) Coeur d'alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Nov. 17 1914

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur d'Alene (No. ....., ... St.)
File No. 3
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Catherine Campbell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: 1 (Month) 3 (Day) 1832 (Year)

7. AGE: 82 yrs. 11 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: James Wilson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gus Campbell
(Address) .....

15. Filed Dec 8 1914 W. H. Holland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 7th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1914, to Dec 7th 1914
that I last saw her alive on Dec 6th 1914
and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs

..... (Duration) ..... yrs. ..... mos. 3 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunby M. D.
Dec 7 1914 (Address) Coeur D'alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Leclede
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Gus Nelson
ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 22

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gretchen Heyn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar. (Month) 23 (Day) 1899 (Year)

7. AGE: 15 yrs. 6 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Henry Heyn

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Pingle

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Heyn
(Address) .....

15. Filed Nov 21 1914 Max C. Ward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 20 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1914, to Nov. 20 1914
that I last saw h er alive on Nov 19 1914
and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Endocarditis with Embolism (Cerebral)

..... (Duration) — yrs. 6 mos. — ds.
Contributory (Secondary) Acute Rheumatism
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Meyer M. D.
Nov 21 1914 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Cassedy & Nelson
ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No: 1014
Registered No. 24

1. PLACE OF DEATH.

County of Kootenai
City of Cœur d'Alene (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clifford Healey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... Yrs. 7 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Homer Healey

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Ethel Snyder

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Homer Healey
(Address) Lake View Idaho

15. Filed Nov. 30 1914 M. A. Stanard Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 29 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: No physician in attendance

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Lake View Idaho

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Ralston Wash
DATE OF ~~BURIAL~~: Dec 1 1914

20. UNDERTAKER: S. Lewis
ADDRESS: C D G

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Shoshone

Primary Registration District No. 2051

File No. 1115

City of Gem

(No. ....., ... St.)

Registered No. 4440

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Brown

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	W	— (Write the word.)

6. DATE OF BIRTH

Dont Know 1
(Month) (Day) (Year)

7. AGE

about 40 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Cattle

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE — (State or Country)

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER — (State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER — (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. F. Brennan

(Address) Gem

15.

Filed 12/10 1914 D. F. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 25 — 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Dont Know. Found dead
in Cabin in Woods
2 miles from attack

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. F. Brennan M. D.

1/26 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gem	1/27 1914
20. UNDERTAKER	ADDRESS
Bobs & Sons	Gem

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No.
Registered No. 4939
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gustav R Klopfer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: M (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1863 (Year)

7. AGE: 51 yrs. 5 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Frederick Klopfer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Pauline Goldsmith

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Lottie Klopfer
(Address) Rathdrum Ida

15.
Filed 12/10 1914 D D Freeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3 1914, to Nov. 24 1914, that I last saw him alive on Nov 24 1914, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever Septic
Perforation of Bowel
(Duration) yrs. mos. 21 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D D Freeman M. D.
11/25 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum — DATE OF BURIAL: 11/29 1914
20. UNDERTAKER: Wilmot — ADDRESS: Spokane

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 17
Primary Registration District No. 2051
(No. ....., ... St.)

File No. 11.
Registered No. 438
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Single

6. DATE OF BIRTH
Nov. 15. 191X
(Month) (Day) (Year)

7. AGE
— yrs. — mos. — ds.
IF LESS than 1 day how many 15 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Rathdrum, Ida.

10. NAME OF FATHER Charles H. Davis

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Edith M. Jenkinson

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles H. Davis
(Address) Rathdrum, Ida.

15.
Filed 12/10 1914 D. D. Drummond
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
November 15. 191X
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15. 191X, to Nov. 15. 191X, that I last saw him alive on Nov. 15. 191X, and that death occurred on the date stated above, at 11. P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth (about 6 mos.)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Young M. D.
11/16. 191X (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rathdrum — DATE OF BURIAL Nov. 191X

20. UNDERTAKER Bob Jones — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

Primary Registration District No. 2059

File No. [illegible]

County of Ada

City of Boise (No. ....., ... St.)

Registered No. 437

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Frank Williams

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F	W	M (Write the word.)

6. DATE OF BIRTH: Jan (Month) 5 (Day) 18[illegible] (Year)

7. AGE: ..... yrs. ..... mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Frank Williams

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Mike Bracken

13. BIRTHPLACE OF MOTHER (State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. Williams
(Address) Boise

15. Filed 11/2 191[illegible] J D Duncan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 16 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 — 191[illegible], to — Nov 15 191[illegible], that I last saw h..... alive on " " 191[illegible], and that death occurred on the date stated above, at [illegible] P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar Pneumonia Opening into Pleural Cavity

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Duncan M. D.

11/15 19 19[illegible] (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ada	Nov 16 191[illegible]
20. UNDERTAKER	ADDRESS
None	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)
File No.
Registered No. 4432
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William A. Reinhart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH July 8 (Month) (Day) 1847 (Year)

7. AGE 70 yrs. 4 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Peter Reinhart

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Jane Reinhart

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Reinhart
(Address) Rathdrum Idaho

15. Filed 12/10 1914 D. D. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25 1914, to Nov. 11 1914, that I last saw h..... alive on 11 11 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) Age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Freeman M. D.

11/11 1914 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rathdrum | DATE OF BURIAL 11/13 1914

20. UNDERTAKER E. E. Bob & Son | ADDRESS Rathdrum Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Cleico
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 17
Primary Registration District No. 2057
(No. ....., ... St.)

File No. 111
Registered No. 436

2. FULL NAME Charles E Brenner

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH
Dec br. 12. 1883
(Month) (Day) (Year)

7. AGE
30 yrs. 10 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mich.

10. NAME OF FATHER Charles Brenner

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Amelia Mc Intyre

13. BIRTHPLACE OF MOTHER (State or Country) Don't Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Catherine Brenner
(Address) Chicago Ida.

15.
Filed 12/10 1914 S. D. Stewart
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Novbr. 5th 191 4
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 29th 191 4, to Nov. 5. 191 4, that I last saw him alive on Novbr. 5. 191 4, and that death occurred on the date stated above, at 4.30 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. 1 mos. ds.

(Signed) Frank King M. D.
11/6 1914 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lead South Dacota — DATE OF BURIAL: 191

20. UNDERTAKER: Doke & Doke. — ADDRESS: Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2147
File No. 9692
Registered No. 78

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calvin Shoop
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. 21 (Month) (Day) 1841 (Year)

7. AGE: 73 yrs. 1 mos. 5 ds. 0
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Shoop

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Day

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orah Watkins
(Address) Moscow.

15. Filed Dec 29 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21 1914, to Nov. 27 1914, that I last saw him alive on Nov 27 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Chronic Pericarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas L Gilman M. D.
Dec 29 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 12/29 1914

20. UNDERTAKER: Geo Stitz | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

1

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. [illegible]
Registered No. 77

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Fylden

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1914 (Year)

7. AGE: ..... Yrs. 1 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Latah Co Idaho

10. NAME OF FATHER Casper Fylden

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Cora Ellingson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Casper Fylden
(Address) Moscow

15. Filed Dec 18 191.... D F Rae Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no physician 191.... to ..... 191....,
that I last saw h..... alive on ..... 191....,
and that death occured on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:
not known. died suddenly
suspected Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Casper Fylden M. D.
19.... (Address) Moscow Father

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Dec 19 1914

20. UNDERTAKER: Home, Father acts — ADDRESS: Moscow

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

61

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 2141
(No. 6, St.)

File No.
Registered No. 81
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME G. L. Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	widower

6. DATE OF BIRTH
Feb (Month) 27 (Day) 1838 (Year)

7. AGE
76 yrs. 10 mos. 18 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ok

10. NAME OF FATHER Noble Rogers

11. BIRTHPLACE OF FATHER (State or Country) Con

12. MAIDEN NAME OF MOTHER Mary Baitz

13. BIRTHPLACE OF MOTHER (State or Country) N Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G A Rogers
(Address) Moscow Idaho

15. Filed Dec 14 1914 D. F. Parr Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1914, to Dec 14 1914, that I last saw h— alive on Dec 12 1914, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Bronchs Pneumonia

(Duration) yrs. mos. 7 ds.
Contributory (Secondary) Old Age
(Duration) yrs. mos. ds.

(Signed) J. N. Clarke M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Moscow | DATE OF BURIAL Dec 16 1914

20. UNDERTAKER Geo Slatty | ADDRESS Moscow

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

County of Latah

Primary Registration District No. 2141

City of Moscow

File No. 1914

(No. ....., ... St.)

Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	Single

6. DATE OF BIRTH

Dec. (Month) 21 (Day) 1914 (Year)

7. AGE

..... yrs. ..... mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow - Idaho.

10. NAME OF FATHER G. C. Spray

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER N. E. Davis

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G C Spray

(Address) Moscow

15. Filed Dec 27 1914 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Baby Spray.

16. DATE OF DEATH

December (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 21 1914, to December 26 1914, that I last saw him alive on December 26 1914, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Malformation.

Imperforate anus

..... (Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) Chas. F. Gritman

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Dec 28 1914

20. UNDERTAKER: Geo Getty | ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow, Id.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 1114
Registered No. 82
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marvin Nathaniel Oberg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~. (*Write* the word.)

6. DATE OF BIRTH: Dec. 13th 1914
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 9 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow Idaho

10. NAME OF FATHER Erick N. Oberg.

11. BIRTHPLACE OF FATHER (State or Country) Sweden!

12. MAIDEN NAME OF MOTHER Minnie Peterson.

13. BIRTHPLACE OF MOTHER (State or Country) S. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Erick N. Oberg
(Address) Moscow Idaho

15. Filed Dec 24 1914 D F Race
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. 24th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 16 1914, to Dec 24th 1914, that I last saw him alive on Dec 24th 1914, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) Premature Birth.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Carothers M. D.

Dec 24 1914 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Id. DATE OF BURIAL: Dec 26th 1914

20. UNDERTAKER: Stoltz ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. .... St.)

File No. 1104
Registered No. 80

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma E Zeseger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 7 (Month) 24 (Day) 1858 (Year)

7. AGE 56 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmers wife

9. BIRTHPLACE (State or Country) California

10. NAME OF FATHER John Ramsey

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Rosena Arn

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P J Zeseger
(Address) Moscow Ida

15. Filed Dec 15 1914 — D F Rae, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1914, to Dec 14 1914, that I last saw her alive on Dec 7 1914, and that death occured on the date stated above, at 4:10 A.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

.....(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Arterio Sclerosis
.....(Duration) ... yrs. ... mos. ... ds.

(Signed) D F Rae M. D.
Dec 15 1914 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Dec 16 1914

20. UNDERTAKER: Geo Stitz — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

8VMS - YORK CO., PTRS. & BORS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 1114
Registered No. 84
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maxine H. Ross.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 8. (Day) 1914. (Year)

7. AGE: ..... yrs. 1 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow

10. NAME OF FATHER: Harry Ross.

11. BIRTHPLACE OF FATHER (State or Country): Idaho -

12. MAIDEN NAME OF MOTHER: Lula Carver.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Allie Carver.
(Address) Moscow -

15. Filed Dec 28 1914 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December 27 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1914, to Dec 27 1914, that I last saw her alive on Dec 26 1914 and that death occurred on the date stated above, at 1.20 A.M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
+ Oedema of throat

..... (Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Asbury M. D.
Dec 27 1914 (Address) Moscow Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Dec 28 1914

20. UNDERTAKER: Geo Stitz | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 34
County of Elmore Primary Registration District No. 2020
City of Mountain Home (No. ....., ... St.)
File No. 1114
Registered No. 27
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.
2. FULL NAME Mary Lucetta Daugherty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
6. DATE OF BIRTH: Oct 21 1908 (Month) (Day) (Year)
7. AGE: 6 yrs. 1 mos. 20 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.*?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Oregon
10. NAME OF FATHER Charley W Daugherty
11. BIRTHPLACE OF FATHER (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Sadat McKenna
13. BIRTHPLACE OF MOTHER (State or Country) Oregon
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charley W Daugherty R.W.L.F.
(Address) Mountain Home Ida
15. Filed Dec. 11th 1914 R W Mathe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 11 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1914 to 11 1914
that I last saw her alive on Dec 11 1914
and that death occurred on the date stated above, at 12 07 A.M.
The CAUSE OF DEATH* was as follows:
Scarlet fever
..... (Duration) ..... yrs. ..... mos. 4 ds
Contributory (Secondary) Cerebro Spinal Meningitis
..... (Duration) ..... yrs. ..... mos. 9 hrs ds
(Signed) W. L. Frazer M. D.
12-11 1914 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home
DATE OF BURIAL: Dec. 11th 1914
20. UNDERTAKER: J. M. Cowen
ADDRESS: Mtn. Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 34
County of Elmore Primary Registration District No. 2020
City of Mountain Home (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 9700
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theresa Harley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: March 31 (Month) (Day) 1831 (Year)

7. AGE: 83 yrs. 9 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Leadley

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary St. Clair
(Address) Weiser Idaho

15. Filed Dec. 22nd 1914 B.O. Mather Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 22nd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20th 1914, to Dec. 22nd 1914, that I last saw h er alive on Dec. 21st 1914, and that death occurred on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH* was as follows:
Arterio - Sclerosis

(Duration) 3 yrs. mos. ds.
Contributory (Secondary) Intestinal paresis
(Duration) yrs. 2 mos. ds.

(Signed) B.O. Mather M. D.
12/22 1914 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho
DATE OF BURIAL: Dec 23 1914

20. UNDERTAKER: J.M. Owen
ADDRESS: Mountain Home Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 Rev. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 1111
Registered No. 28

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James McKeen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unknown

6. DATE OF BIRTH. Dec (Month) unknown (Day) 1914 (Year)

7. AGE: 57 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boston, Mass

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Blair
(Address) none

15. Filed Dec 18 1914 B. W. Mather Local Registrar

BYRNE - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 1:40 P.M.

The CAUSE OF DEATH* was as follows:
Came to his death by being struck by Extra West Bound 888

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Evans M. D.
12/18 1914 (Address) Mtn Home Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home
DATE OF BURIAL: 12/19 1914

20. UNDERTAKER: J. M. Cowen
ADDRESS: Mtn Home

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 20 11

File No. 9711

County of Adams

City of Council (No. ....., ... St.)

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ni Name

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Oct 31 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER G. W. Santee

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER L. B. Santee

13. BIRTHPLACE OF MOTHER (State or Country) Cal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. W. Santee
(Address) .....

15. Filed 11-6-1914 Frank E Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 1 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw him alive on ..... 191..., and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Inanition

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E Brown M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Council	Nov 1 1914

20. UNDERTAKER	ADDRESS
Roop Young	Council

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 210
Primary Registration District No.
(No. , St.)

File No. 9703
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Margaret Ellen Vaughn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Nov (Month) 14 (Day) 1853 (Year)

7. AGE: 61 yrs. — mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: James K. Crabb

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Rhoda McDonald

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennette E. Hinkley
(Address) Riggins Idaho

15.

Filed Dec 15 1914 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9th 1914, to Dec 10 1914
that I last saw h[er] alive on Dec 10 1914,
and that death occurred on the date stated above, at 6.20 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. O. Clark M. D.
Dec 11 1914 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council Idaho
DATE OF BURIAL: 191

20. UNDERTAKER: C. D. Buckner
ADDRESS: Emmett Ida

OWNS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1711

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. **PLACE OF DEATH.** Registration District No. 2010

County of Canyon Primary Registration District No.

City of Emmett (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Peter Kessler

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** male

4. **COLOR OR RACE** white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (*Write* the word.) Married

6. **DATE OF BIRTH** July (Month) 10 (Day) 1848 (Year)

7. **AGE** yrs. 66 mos. 4 ds. 21 days IF LESS than 1 day how many ..... hrs. or min.?

8. **OCCUPATION**
(a) Trade, professsion, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Luxemburg-Clausen

10. **NAME OF FATHER** Dont Kessler

11. **BIRTHPLACE OF FATHER** (State or Country)

12. **MAIDEN NAME OF MOTHER** Catherine Kessler

13. **BIRTHPLACE OF MOTHER** (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Matt C. Kessler

(Address) Emmett

15.

Filed Dec 10 1914 J. H. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Dec (Month) 8th (Day) 1914 (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from Dec 5th 1914, to July 1914, that I last saw him alive on Dec 5th 1914, and that death occurred on the date stated above, at 9:40 a. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. O. Clark M. D.

Dec 11 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Emmett Idaho

DATE OF BURIAL Dec 1914

20. **UNDERTAKER** [illegible]

ADDRESS Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of St Charles
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5-5
Primary Registration District No.
(No. , St.)

File No.
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Jacobson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 5 (Day) 1831 (Year)

7. AGE: 84 yrs. 7 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dagstorp Sweden.

10. NAME OF FATHER: Nels Rasmuson.

11. BIRTHPLACE OF FATHER (State or Country): Norrudinge July 1-1807

12. MAIDEN NAME OF MOTHER: Karna Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Soderundinge March 13 1808

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johanna Regnire
(Address) St Charles

15.
Filed Dec 29 1914
John Mattson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No Doctor in attendance
Died of old age

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles — DATE OF BURIAL: Dec 29 1914

20. UNDERTAKER: J A Blade — ADDRESS: St Charles

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake

City of Fish Haven

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5-5-

Primary Registration District No.

(No. ....., ... St.)

File No.

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Frances Findley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: March 31 1862
(Month) (Day) (Year)

7. AGE: 52 yrs. 5 mos. 2 ds.

IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hous Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake Utah.

10. NAME OF FATHER: Henry Howell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Frances Goble

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Wm Findley
(Address) Fish Haven

15.
Filed Sept 16 1914 John Mathon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 2 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Intestinal obstruction

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Intestinal hernia
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A L Cooley M. D.
19.... (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fish Haven | DATE OF BURIAL: Sept 4 1914

20. UNDERTAKER: Wm H Shirley | ADDRESS: Fish Haven

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 116

County of Bingham

Primary Registration District No. 2193

File No. 1

City of Aberdeen (No. ....., ... St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lizzie Livingstone Neville

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 16 1878 (Month) (Day) (Year)

7. AGE: 36 yrs. 6 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: John Livingstone

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Marion Kennedy

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Livingstone
(Address) Aberdeen

15. Filed Dec 12 1914 M. Cinnamon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 12 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914 to Dec 12 1914 that I last saw h alive on Dec 12 1914 and that death occurred on the date stated above, at 12 40 M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) — yrs. 6 mos. — ds.

Contributory (Secondary) Dropsy

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) M. Cinnamon M. D.

Dec 12 1914 (Address) Aberdeen, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodruff Utah — DATE OF BURIAL: Dec 15 1914

20. UNDERTAKER: H R Hegh — ADDRESS: Am. Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 116

County of Bingham

Primary Registration District No. 2195

City of Aberdeen (No. ....., ... St.)

File No. 1

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine Boese

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb 21 (Month) (Day) 1884 (Year)

7. AGE: 30 yrs. 10 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER Johann Benter

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Dorothea Fickel

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David J Boese
(Address) Aberdeen Ida

15. Filed Dec 31 1914 H. Newman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 30 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1914 to Dec 30 1914 that I last saw h alive on Dec 30 1914 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Inflamation of Gall bladder
& Common bile duct -

(Duration) ..... yrs. ..... mos. 10 ds.,

Contributory (Secondary) Hypostatic Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) H. Newman M. D.

Dec 31 1914 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Belmont Cemetery — DATE OF BURIAL: Jan 3 1915

20. UNDERTAKER A. Brent Gentry — ADDRESS Aberdeen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah.

City of Princeton

Registration District No. 65.

Primary Registration District No. 21 45.

(No. ....., ... St.)

File No. 1111

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ivo Ivanhoe (Mc Vey)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. Dec. (Month) 8 (Day) 1914 (Year)

7. AGE: .....Yrs. ✓ .....Mos. ✓ .....ds. ✓

IF LESS than 1 day how many ..46.. hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... ✓

(b) General nature of industry, business, or establishment in which employed (or employer)..... ✓

9. BIRTHPLACE (State or Country) Princeton · Idaho.

10. NAME OF FATHER: Iva M. Vey.

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER: Katie R. Innes.

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. W Brock.

(Address) Princeton

15. Filed Dec 10 1914

D. W. Travis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8 1914, to Dec 8 1914, that I last saw him alive on Dec 8 1914, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

.....(Duration) .....Yrs. .....mos. 1 ds.

Contributory (Secondary) Placentae Hemmorrhage.

.....(Duration .....yrs. .....mos. .....ds.

(Signed) W. Brock. M. D.

Dec 8 1914 (Address) Princeton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: Dec 9 1914

20. UNDERTAKER: Parents. — ADDRESS: Princeton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
(No. .... St.)

File No. 111
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Latah
City of Princeton
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant McVey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH.
Dec (Month) 8th (Day) 1914 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many. 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER
Ira McVey

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER
Katie R. Sears

13. BIRTHPLACE OF MOTHER
(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. W. Lowe
(Address) Princeton Idaho.

15.
Filed Dec. 10th 1914
D. J. W. Thompson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 8th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8th 1914, 11 hrs. A.M., to Dec 8th 1914, 8 hrs. A.M., that I last saw h... alive on Dec 5 1914, and that death occured on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Placenta Praevia

(Duration ..... yrs ..... mos ..... ds.
(Signed) W. R. McCormick M. D.
19..... (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: Dec. 9th 1914

20. UNDERTAKER: Parents — ADDRESS: Princeton

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of ~~of~~
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65.
Primary Registration District No. 2145.
(No. ....., ... St.)

File No. 111
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Louis Wade

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: August (Month) 30 (Day) 1900 (Year)

7. AGE: 14 yrs. 3 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Henry L. Wade

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Mattie Wirick

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William M Hunter
(Address) Garfield Washington

15.
Filed Dec. 18 - 1914. D. H. Thomson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1914, to Dec 14 1914
that I last saw him alive on Dec 12 1914
and that death occurred on the date stated above, at 3.30 A.M.
The CAUSE OF DEATH* was as follows:

Septic Pneumonia Tuberculosis

..... (Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Diabetes Insipidus
..... (Duration) ..... yrs. ..... mos. few ds.
(Signed) H. E. Mires M. D.
Dec 14 1914 (Address) Garfield Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fresno, Idaho	Dec. 15. 1914
20. UNDERTAKER	**ADDRESS**
F. L. Swim.	Garfield, Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Idaho

~~WASHINGTON~~ STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 1 1 1

File No.

Registered No.

PLACE OF DEATH

County of Latah

City or Town of

Registration Dist. No.

(No. 65 - Primary R. D. No 2145. St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

Full Name Almira Marsh Gibbs

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Caucasian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): widowed.

6 DATE OF BIRTH: July (Month) 5 (Day), 1832 (Year)

7 AGE: 82 yrs. 4 mos. 24 ds. If LESS than 1 day, ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Ohio Ashland Co.

PARENTS

10 NAME OF FATHER: Aretas Marsh.

11 BIRTHPLACE OF FATHER (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Ruth Rice

13 BIRTHPLACE OF MOTHER (State or country): Mass.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Mabel Gibbs
(Address) Garfield, Wash.

15 Filed Nov 30 -, 1914. D. J. Jr. Trumbly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 29 (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1914, to Nov 29, 1914, that I last saw h[illegible] alive on Aug 7 - 1914, and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH * was as follows:

Senile Decay

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Boyd, M. D.

Nov 30 1914. (Address) Palouse Wash.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Freeze. DATE OF BURIAL: Dec 1 - 1914.

20 UNDERTAKER: E. Anderson. ADDRESS: Palouse Wash.

This death occurred in Latah Co Idaho about 8 m. north of Potlatch, on Deep Creek - Per J Dahl, Registrar, Palouse Wash

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 245.
(No. .... St.)

File No. 11
Registered No. .....

1. PLACE OF DEATH.

County of Cataldo
City of Princeton

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Philip Murray Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH.
October 7. 1914
(Month) (Day) (Year)

7. AGE
~~Yrs.~~ 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: Frank Allen

11. BIRTHPLACE OF FATHER
(State or Country) California

12. MAIDEN NAME OF MOTHER: Cora M Bull

13. BIRTHPLACE OF MOTHER
(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. McCarthy
(Address) Princeton Ida.

15.
Filed Dec. 29th 1914
Dr. J. M. Thompson
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24655

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December 27 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1914, to ~~..... 191...~~, that I last saw ~~h..... alive on~~ ~~..... 191...~~, and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:
Congestion of Brain
..... (Duration) Only a few minutes ~~yrs. mos. ds.~~
Contributory (Secondary) Slight cold
(Duration ~~yrs.~~ mos. 3 ds.

(Signed) D. McCarthy M. D.
19.... (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Tendenhall Cemetery — DATE OF BURIAL: Dec. 27th 1914

20. UNDERTAKER: Parents. — ADDRESS: Princeton Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Parma

Registration District No. 3

Primary Registration District No. 9 2 0 0 7

(No. .... St.)

File No. 11

Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John V. Dickerson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 23 (Day) 1847 (Year)

7. AGE: Yrs. 67 Mos. 10 ds. 22

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.. Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Wm Dickerson

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Jane Lafferty

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W L Dickerson

(Address) Holloway Ohio

15.

Filed 12-17 1914 Lulu Waldron Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1912, to Dec 16 1914, that I last saw him alive on Nov 28 1914, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Epithelioma of right side, face and lower

(Duration) 2 Yrs. 5 mos. about ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.

12-17 1914 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma — DATE OF BURIAL: 191

20. UNDERTAKER: O. P. Keller — ADDRESS: Parma

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
File No. 971
Registered No. 50

1. PLACE OF DEATH.
County of Canyon
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob K. Patterman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH. April (Month) — (Day) — 1831 (Year)

7. AGE 79 Yrs. 7 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Jacob Patterman

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. B. Patterman
(Address) Parma, Idaho

15. Filed ..... 191.... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1914, to Dec 14 1914, that I last saw h... alive on Dec 14 1914, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Uremic poisoning
about (Duration) 3 Yrs. — mos. — ds.
Contributory (Secondary) old age
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Medcalf M. D.
Dec 16 1914 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Colfax Wash	..... 191....
20. UNDERTAKER	**ADDRESS**
C. S. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOKS. 24654

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2010
Primary Registration District No. 1010
File No. 971
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Joseph L. Reed

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1847 (Year)

7. AGE: 65 yrs. 10 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Lumberman
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Levi Reed

11. BIRTHPLACE OF FATHER (State or Country): ~~Do not know~~ Tennessee

12. MAIDEN NAME OF MOTHER: Elsie Higgins

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edgar Reed
(Address) Emmett Idaho

15.
Filed 1-6 1915 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1913 to Dec 14 1914, that I last saw him alive on Dec 14 1914, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(Duration) 2 yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.
1-6 1915 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: Dec 18 1914

20. UNDERTAKER: C. D. Bicknell
ADDRESS: Emmett

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11

Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Mary E. Reese

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): single

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1893 (Year)

7. AGE: 21 yrs. 11 mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Household duties
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Edwin Reese

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Farmer

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. P. Reese
(Address) Emmett Idaho

15.
Filed 2-27 1915 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1914, to only 191..
that I last saw h[illegible] alive on Dec 26 1914,
and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:
~~Mitral Endocarditis~~
Mitral Insufficiency
(Duration) yrs. 2 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) B. O. Clark M. D.
Dec 26 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: Dec 28 1914

20. UNDERTAKER: C. D. Buckenum
ADDRESS: Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statisti

1. PLACE OF DEATH.

Registration District No. 82

Primary Registration District No. 2136

File No. 111

County of Bear Lake

City of Montpelier (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Marget Johnson

If death occured in a hospital stitution or camp, give its NA instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1852 (Year)

7. AGE: 62 yrs. 0 mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: John Berg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nina Johnson
(Address) Oxid Idaho

15. Filed 12/31/ 1914 N H Kemp M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 28 (Day) 191 (Ye

17. I HEREBY CERTIFY, That I attended deceased fr
Oct 1 1914, to Dec 28 191
that I last saw h[illegible] alive on Dec 28 191
and that death occurred on the date stated above, at 8 P.

The CAUSE OF DEATH* was as follows:
Exhaustion following opera
for ovarial cyst and
Spurulent appendicita
(Duration) — yrs. — mos. 3
Contributory (Secondary) cystitis & pyelitis
(Duration) 10 yrs. — mos. —
(Signed) L T Hollendorf M.
Dec 29 1914 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institution Transients or Recent Residents.)
At place of death — yrs — mos 3 days. In the State ..... yrs ..... mos ..... da
Where was disease contracted if not at place of death? .....
Former or usual residence Oxid Idaho

19. PLACE OF BURIAL OR REMOVAL: Oxid Idaho | DATE OF BURIAL: Dec 29 191

20. UNDERTAKER: Bishop Lundsay | ADDRESS: Oxid Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 11
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ina Lee Lane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. 5 1914
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 11 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Meridian

10. NAME OF FATHER: J. E. Lane

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Hattie Morris

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Lane
(Address) Meridian

15.
Filed 11-17- 1914
C. L. Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 17 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 191 , to Nov 16 1914 , that I last saw her alive on Nov 16 191 4 , and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Pericardium
Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Talbert F. Neal M. D.
Nov 17 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/17 1914

20. UNDERTAKER: Fuhriken & Liden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of Ada.

Primary Registration District No. 2003

City of Meridian R.D. (No. 2½ Mi. N. of 4½ Mi. N. St.)

File No. 11

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert J Peterson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH: Aug (Month) 16 (Day) 1839 (Year)

7. AGE: 75 yrs. 3 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Jacob Peterson

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Jane Willis

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J T Peterson
(Address) Meridian RD #1

15. Filed NOV-30-1914 C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1914, to Nov 28 1914, that I last saw him alive on Nov 27 1914, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Payne M. D.

11-29 1914 (Address) Nampa R. 2.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs ~~11~~ mos ..... days. In the State 27 yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Ross ... and ... did

19. PLACE OF BURIAL OR REMOVAL: Star Idaho — DATE OF BURIAL: 11-30-1914

20. UNDERTAKER: Ayers — ADDRESS: Star

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 200.
File No. 1 1 2
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Meridian
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Cynthia Ann Aldrich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: August 6 1834 (Month) (Day) (Year)
7. AGE: 80 yrs. 3 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Decatur Co. Ind.
10. NAME OF FATHER: George Gilliland
11. BIRTHPLACE OF FATHER (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Sarah Scott
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred Adams
(Address): Meridian
15.
Filed 11-23-1914 C. L. Sutton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 22 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to Nov 16 1914, that I last saw her alive on Nov 16 1914, and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Leakage of
A. V. valve Prob. old
attack asthma
(Duration) yrs. 12 mos. ds.
Contributory (Secondary) Asthma
(Duration) yrs. mos. ds.
(Signed) J. F. Neal M. D.
Nov 23 1914 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill
DATE OF BURIAL: Nov 23 1914
20. UNDERTAKER: Fry & Summers
ADDRESS: Boise.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

Registration District No. 36

Primary Registration District No. 5

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29726

Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcus L Tennant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Widowed

6. DATE OF BIRTH June 3 1839
(Month) (Day) (Year)

7. AGE 75 yrs. 6 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Rancher
(b) General nature of industry business or establishment in which employed (or employer) ..... Farmer

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Allen Tennant

11. BIRTHPLACE OF FATHER (State or Country) Scotch Ireland

12. MAIDEN NAME OF MOTHER Jemima Mott

13. BIRTHPLACE OF MOTHER (State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W Tennant
(Address) Kimberly Ida

15.
Filed Dec 20 1914 Dr J M Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 20 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1914, to Dec 20 1914
that I last saw him alive on Dec 20 1914
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

24 hrs
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Organic heart disease
(Duration) unknown yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.
Dec 20 1914 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Removed to Nampa, Idaho,

19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida
DATE OF BURIAL Dec 22 1914

20. UNDERTAKER D Marsh
ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Genesee.
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 11
Registered No. 14
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abigail Roderick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	White	married

6. DATE OF BIRTH Jan. (Month) 27 (Day) 1843 (Year)

7. AGE 71 yrs. 11 mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Johnathan W. Day.

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Rotchel McCord

13. BIRTHPLACE OF MOTHER (State or Country) Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Newman
(Address) Genesee Idaho

15. Filed 12-28 1914 L. O. McKeen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1914, to Dec 26 1914, that I last saw h[illegible] alive on Dec 26 1914 and that death occurred on the date stated above, at 6.30 A.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. Turney M. D.
Dec 27 1914 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moore	12-28 1914

20. UNDERTAKER	ADDRESS
I. E. Lambert	Genesee Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 2142
(No. ....., ... St.)

File No. .....
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Cann

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 6 (Day) 1867 (Year)

7. AGE: 47 yrs. 6 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): Housework

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Edward Roderick

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Sarah A Sayre

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul L Cann
(Address) Genesee Ida

15. Filed 12-8 1914 W H Ehrhardt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1914, to Dec 7 1914, that I last saw h[illegible] alive on Dec 7 1914 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

10 yrs 2 m (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C T Brown M. D.

Dec 8 1914 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL ~~OR REMOVAL~~: I.O.O.F. Cem. DATE OF BURIAL: 12 [illegible] 9 1914

20. UNDERTAKER: E. Lambert ADDRESS: Genesee Ida

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
(No. , St.)

Registration District No. 64
Primary Registration District No. 2144

File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ~~Ulrich~~ C Rietmann

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: July (Month) 1 (Day) (Year)

7. AGE: 67 yrs. 1 mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Henry Reichtman

11. BIRTHPLACE OF FATHER (State or Country): Canton St Gall Switzerland

12. MAIDEN NAME OF MOTHER: (unknown)

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Max Rietmann
(Address) Troy Idaho.

15.
Filed Aug 11 1914 C. V. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1914, to Aug. 10 1914
that I last saw him alive on Aug. 9 1914
and that death occurred on the date stated above, at 4a. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 yrs. — mos. — ds.

Contributory (Secondary) Pneumonia

(Duration) — yrs. — mos. 10 ds.

(Signed) J. M. Carroll M. D.

Aug 11 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burnt Ridge	Aug 11 1914
20. UNDERTAKER	**ADDRESS**
John Olson	Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 7144
(No. ..... St.)
File No. 1107
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Axel Leonard Swanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb. (Month) 18 (Day) 1914 (Year)
7. AGE: ..... Yrs. 8 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Troy Idaho
10. NAME OF FATHER: Axel Swanson
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Nellie Dahlin
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Axel Swanson
(Address) Troy Idaho
15. Filed 10-18-1914. C. J. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 18 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 15 1914, to Oct 18 1914, that I last saw him alive on Oct 16 1914, and that death occured on the date stated above, at 2a M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) — Yrs. — mos. 10 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Cole M. D.
Oct 18 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge Cemetary — DATE OF BURIAL: Oct 20 1914
20. UNDERTAKER: F O Swanson — ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

File No. 9731
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charles Wilbur Bishop

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. 11 1887 (Month) (Day) (Year)

7. AGE: 27 yrs. 6 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Harvey Bishop

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Millie (Unknown)

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Hylton
(Address) Troy Idaho

15. Filed Dec 6 1914 C. V. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1914, to Dec. 5 1914, that I last saw him alive on Dec 5 1914, and that death occurred on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) — yrs. — mos. 23 ds.

Contributory (Secondary) Intestinal Perforation

(Duration) — yrs. — mos. 1 ds.

(Signed) J. M. McCall M. D.

Dec 5 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Cemetary — DATE OF BURIAL: Dec 6 1914

20. UNDERTAKER: Geo Brocke — ADDRESS: Troy Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ..... St.)

File No. 11
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME LeVern Strom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec 12 (Month) 12 (Day) 1914 (Year)

7. AGE: X yrs. X mos. 2 wks X ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Troy

10. NAME OF FATHER: Albert Strom

11. BIRTHPLACE OF FATHER (State or Country): Minnesta

12. MAIDEN NAME OF MOTHER: Cecelia Sawson –

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Strom
(Address) Troy Idaho

15. Filed 12-27- 1914 C. E. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1914, to Dec 27th 1914
that I last saw him alive on Dec 27th 1914
and that death occurred on the date stated above, at 4 a. M.
The CAUSE OF DEATH* was as follows:
Inanition

..... (Duration) ..... yrs. ..... mos. 14 ds.
Contributory (Secondary) Premature Birth
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Olson M. D.
Dec 27 1914 (Address) Spokane Wn.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burns Dedye
DATE OF BURIAL: 12-28-1914

20. UNDERTAKER: Swante Johnson
ADDRESS: Troy Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 95

Primary Registration District No. 2171

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Lenore P.O.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of G. V. Faekenthal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... /

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER G. V. Faekenthal

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Carrie Bolyard

13. BIRTHPLACE OF MOTHER (State or Country) W. Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. V. Faekenthal

(Address) Lenore

15. Filed 11-16- 1914

J. McGrath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11- (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Premature Vitality

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. McGrath M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lumpsed Cemetery — DATE OF BURIAL: 11-17 1914

20. UNDERTAKER: None — ADDRESS: /

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2117
File No. 11
Registered No. 63

1. PLACE OF DEATH.
County of Franklin
City of Preston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Aksel Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. May (Month) 28 (Day) 1897 (Year)
7. AGE: Yrs. 17 Mos. 6 ds. 14
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Denmark
10. NAME OF FATHER: Rasmus Anderson
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Christina Clausen
13. BIRTHPLACE OF MOTHER (State or Country): Denmark
14. THE ABOVE I[illegible]E TO THE BEST OF MY KNOWLEDGE.
(Informant) [illegible]
(Address) Preston
15. Filed Jan. 10 1915 Dr Allen R Reeder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 12 (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 24 1914, to Dec 12 1914, that I last saw him alive on Dec. 12 1914, and that death occured on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever.
(Duration) Yrs. 1 mos. 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Allen R Reeder M. D.
19 (Address) Burton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: Dec. 15 1914
20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1[illegible]
Registered No. 64

1. PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Deloris Fay Brimhall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Oct. 16 (Month) 1914 (Day) (Year)

7. AGE: ..... yrs. 1 mos. 29 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Preston

10. NAME OF FATHER: Alma Brimhall

11. BIRTHPLACE OF FATHER (State or Country): Union Utah

12. MAIDEN NAME OF MOTHER: Clara Dorius

13. BIRTHPLACE OF MOTHER (State or Country): Ephriam Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burt Brimhall
(Address) Preston Idaho

15.
Filed Jan. 10 1915 D. Allen Reeder
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1914, to Dec 14 1914
that I last saw her alive on Dec 14 1914
and that death occurred on the date stated above, at 9:30 a M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

..... (Duration) ..... yrs. 2 mos. 3 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
Dec 15 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: Dec. 15 1914

20. UNDERTAKER: No undertaker
ADDRESS:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE. 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 11
Registered No. 65
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lois Hawkes Goaslind

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Jan (Month) 25 (Day) 1914 (Year)

7. AGE: ..... yrs. 10 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Franklin Co Idaho

10. NAME OF FATHER Charles Earl Goaslind

11. BIRTHPLACE OF FATHER (State or Country) Franklin Idaho

12. MAIDEN NAME OF MOTHER Lois Hawkes

13. BIRTHPLACE OF MOTHER (State or Country) Preston

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C D Goaslind
(Address) Preston Idaho

15.
Filed Jan. 10 1914 D Allen Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 3 1914, to Dec. 10 1914, that I last saw h[illegible] alive on Dec 10 1914, and that death occurred on the date stated above, at 11-15 M.

The CAUSE OF DEATH* was as follows:
Empy empitas over 1/3 of whole body - & bowel trouble with bloating
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D Allen Curtis M. D.
12/12 1914 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: Dec. 12 1914

20. UNDERTAKER: W. A. Gilmore
ADDRESS: Preston

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Preston (No. Mtn Creek, St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119

File No. 9738
Registered No. 66
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander Baird

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Jan. 10 (Month) 1832 (Day) (Year)

7. AGE
82 yrs. 11 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Laborer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Scotland

10. NAME OF FATHER Robert Baird

11. BIRTHPLACE OF FATHER
(State or Country) Scotland

12. MAIDEN NAME OF MOTHER Agnes Belle

13. BIRTHPLACE OF MOTHER
(State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Baird
(Address) Mink Creek, by P. O. Idaho

15.
Filed Jan 10 1914 D Allen R Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. 31 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Physician in attendance 191..., to ..... 191...,
that I last saw h ✓ alive on ✓ 191...,
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Senile decay — in all that was known

(Duration) yrs. one mos. — ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Allen R Cutler M. D.
19... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Brigham	Jan. 4 1914

20. UNDERTAKER	ADDRESS
W. A. Saldmore	Preston

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kootenia
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 11
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Arthur Talcott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
(Month) Dec (Day) 16 1912

7. AGE
1 yrs. 11 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: that of a Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kans

10. NAME OF FATHER: C A Talcott

11. BIRTHPLACE OF FATHER (State or Country): Kans

12. MAIDEN NAME OF MOTHER: I K Wathor

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C A Talcott
(Address) Kootenia

15.
Filed Dec 12, 1914 Jm Vetterlein Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1914, to Dec 10 1914, that I last saw him alive on Dec 10 1914 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(Duration) yrs. mos. 8 ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) Jm Vetterlein M. D.
Dec 1914 (Address) Kootenia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kootenia Cemetery
DATE OF BURIAL: Dec 12 1914

20. UNDERTAKER: C J Johnson
ADDRESS: Kootenia Ida

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Burke
(No. ..... St.)
Registration District No. 122
Primary Registration District No. 2205
File No. 1425
Registered No. 28
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rhoda Gray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE: 81 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Rhoda Tway

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rhoda Richardson
(Address) Wardner Idaho

15. Filed DEC 14 1914 W. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
DEC (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from DEC 1914 to DEC 12 1914, that I last saw h alive on NOV 13 1914 and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Uremia
(Duration) several mos. ds.
Contributory (Secondary) Old Age
(Duration) yrs. mos. ds.
(Signed) D. S. Mowery M. D.
12/14 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace
DATE OF BURIAL: Dec 16 1914

20. UNDERTAKER: Ward Undertaking Co
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 122
County of Shoshone
Primary Registration District No. 2200
City of Wallace (No. ....., ... St.)
File No. .....
Registered No. 29
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leon Mouchet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
40 yrs. — mos. —— ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Mr. Mouchet

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Mrs. Jaussin

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Mouchet
(Address) Kellogg, Idaho

15.
Filed 12/25 1914 H. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on ..... 191...,
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows: Fell through chute
Compound Fracture of Skull
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. C. Mowery M. D.
12/24 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wardner Idaho
DATE OF BURIAL: Dec 26th 1914

20. UNDERTAKER: Ward Undertaking Co
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1220.
Primary Registration District No. 2200.
File No. 1111
Registered No. 30

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Mace, at Standard Mine, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James McCarthy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 1 (Month) (Day) 1894 (Year)

7. AGE: 20 Yrs. 5 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cork, Ireland

10. NAME OF FATHER: James McCarthy

11. BIRTHPLACE OF FATHER (State or Country): Cork Ireland

12. MAIDEN NAME OF MOTHER: Myra Sullivan

13. BIRTHPLACE OF MOTHER (State or Country): Cork Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James M. Carthy
(Address) Burke Idaho

15. Filed 12/25 1914 H. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: DEC (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Perforating wound right side chest accidentally received
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Dr H Mowery M. D.
Dec 24 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte, Montana. DATE OF BURIAL: 12/25 1914.

20. UNDERTAKER: Bruce & Worstell ADDRESS: Wallace, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2200
File No. 114
Registered No. 21

1. PLACE OF DEATH.
County of Shoshone
City of Wallace Id
(No. Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Shearer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
(Month) (Day) (Year)

7. AGE: 45 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John F. Corbett
(Address) Mace Idaho

15. Filed 12/25 1914 W. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ....,
and that death occured on the date stated above, at [redacted] M.
THE CAUSE OF DEATH* was as follows:
Accidental
fracture skull
— mine accident
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.
(Signed) Dr Mowery M. D.
1926 1914 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Dec 27 1914

20. UNDERTAKER: Chas G Morton — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 914
Registered No. 32

1. PLACE OF DEATH.
County of Shoshone
City of Mullan

Registration District No. 122
Primary Registration District No. 2200
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacks Korpi

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 4 (Day) 1878 (Year)

7. AGE: 36 yrs. 0 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Joseph Korpi

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jacks Korpi
(Address) Mullan Ida

15.
Filed Dec 25 1914
H G Moberly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1914, to Dec 24 1914, that I last saw h[illegible] alive on 24 day Dec 1914 and that death occurred on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

8 (Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F W Rolfs M. D.
Dec 25 1914 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER Moratelli Undertaking | ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47

County of Lewis

Primary Registration District No. 21 24

File No. 111

City of Nezperce

(No. ....., ... St.)

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Henry Siems

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Married

6. DATE OF BIRTH

April 10 1864
(Month) (Day) (Year)

7. AGE

50 yrs. 7 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Dietrich Siems

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Rebecca Wichman

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Henry Siems

(Address) Nezperce Idaho

15.

Filed 12-5- 1914 J. L. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occurred on the date stated above, at 3. P. M.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Parrish Coroner M. D.

12-5 1914 (Address) Nez Perce Co. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Idaho — DATE OF BURIAL: Dec. 6 1914

20. UNDERTAKER: P. E. Miller — ADDRESS: Nezperce Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47
Primary Registration District No. 2124
(No. ....., ... St.)

File No. 11
Registered No. 13
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Wm Boulton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Apr. (Month) 20 (Day) 1866 (Year)

7. AGE: 48 yrs. 7 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ger.

10. NAME OF FATHER: Wm Boulton

11. BIRTHPLACE OF FATHER (State or Country): Ger

12. MAIDEN NAME OF MOTHER: Wilhelmina Mauska

13. BIRTHPLACE OF MOTHER (State or Country): Ger.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Wm Boulton
(Address) Nezperce

15.
Filed Dec 18 1914 J B Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Dec 15 1914, to ..... 191..
that I last saw him alive on Dec 15 1914
and that death occurred on the date stated above, at 2 9. M.
The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
..... several years
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Asthma several years
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. A. J. Kramer M. D.
Dec 18 1914 (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce
DATE OF BURIAL: Dec 19 1914

20. UNDERTAKER: Star Hardware Co
ADDRESS: Nez, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 22 11 1
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Cottonwood (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183

2. FULL NAME Jasmus H. Rink

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Feb 17 (Month) (Day) 1837 (Year)

7. AGE: 77 yrs. 9 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Reitzel Rink

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: H. C. Reitzel

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Rink
(Address) Cottonwood

15. Filed Dec 5th 1914 Nov 5 1914 H Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1914, to Dec 4 1914
that I last saw him alive on Dec 4 1914,
and that death occurred on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:
Acute Hepatitis,
..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Acute cystitis, Acute nephritis
..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J. D. Simmack M. D.
Nov 5 1914 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: Dec 6 1914

20. UNDERTAKER: Harry M West — ADDRESS: Cottonwood Ida

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 105
County of Idaho Primary Registration District No. 2183
City of Ferdinand (No. ....., ... St.)
File No. 21
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura May Martin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: March (Month) 9th (Day) 1913 (Year)

7. AGE: 1 yrs. 8 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ellery P. Martin

11. BIRTHPLACE OF FATHER (State or Country) Winfield, Kansas

12. MAIDEN NAME OF MOTHER Blanch C Fry

13. BIRTHPLACE OF MOTHER (State or Country) Bronaugh Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edgar G. Fry
(Address) Cottonwood Idaho

15. Filed Dec 9th 1914 H Wooten Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ On Dec 8th 1914, to ..... 191..
that I last saw her alive on About Sept 20 1913,
and that death occurred on the date stated above, at 12 75a. M.

The CAUSE OF DEATH* was as follows:
Causes (natural) Unknown
H Wooten M D
Coroner Idaho County Ida.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Turner, M. D.
12-9-1914 (Address) Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: Dec 9 1914

20. UNDERTAKER: Harry M West — ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 1
Registered No. 11

1. PLACE OF DEATH.
County of Latah
City of Deary
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chester Wats Perry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	single

6. DATE OF BIRTH: Dec (Month) 4 (Day) 1914 (Year)

7. AGE: 0 yrs. 0 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Joe S. Perry

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Carrie Young.

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Packard
(Address) Deary

15. Filed 12/26 1914 W. V. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
some kind of spasm

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) prematurebirth
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Home place | DATE OF BURIAL: Dec 26 1914

20. UNDERTAKER: J. E. Pickerd | ADDRESS: Deary Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Deary
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. 1, St.)

File No. 1
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Syvria E Berg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: Jan. (Month) 2 (Day) 1844 (Year)

7. AGE: 70 yrs. 11 mos. 22 ds.
IF LESS than 1 day how many .....*hrs. or* .....*mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): norway

10. NAME OF FATHER: Engebret Berg

11. BIRTHPLACE OF FATHER (State or Country): norway

12. MAIDEN NAME OF MOTHER: Johanna Halvorsen

13. BIRTHPLACE OF MOTHER (State or Country): norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. C. Faust
(Address) Deary Ida.

15. Filed 12/26 1914 P. C. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h... alive on — 191...,
and that death occurred on the date stated above, at — M.
The CAUSE OF DEATH* was as follows:
accidental - fall & drowning in a cistern
(Duration) — yrs. — mos. — ds.
Contributory (Secondary) weak & nervous
(Duration) — yrs. — mos. — ds.
(Signed) P. C. Faust M. D.
12/26 1914 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Zion Cemetery | DATE OF BURIAL: Dec 28, 1914
20. UNDERTAKER: — | ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2147

Primary Registration District No. 67

File No. 1

County of Latah

City of Helmer (No. ....., ... St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Mc. Intyre

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write the word.*): single

6. DATE OF BIRTH: Aug. (Month) 21 (Day) 1912 (Year)

7. AGE: 2 yrs. 4 mos. 9 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Geo. Mc. Intyre

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Ethel Vandvanter

13. BIRTHPLACE OF MOTHER (State or Country): Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Faust
(Address) Deary Ida.

15. Filed 12/31 191 4 R. E. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 30 (Day) 1914 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23 1914, to Dec. 30 1914, that I last saw h. alive on Dec 30 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
auto intoxication
(Intestinal).

(Duration) — yrs. — mos. 14 ds.

Contributory (Secondary) laryngitis

(Duration) — yrs. — mos. 1/2 ds.

(Signed) R. E. Faust M. D.

12/31 1914 (Address) Deary.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moscow Cemetery | DATE OF BURIAL: 12/31 1914

20. UNDERTAKER: — | ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Mac

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 975
Registered No. 667

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2183
(No. ....., ... St.)

2. FULL NAME Anna Olivia Olson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	married

6. DATE OF BIRTH: Apr (Month) 7 (Day) 1866 (Year)

7. AGE: 48 yrs. 7 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Carl Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Caren Holms

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thom Olson
(Address) Dover Idaho

15. Filed Jan 8 1915 E. M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1914, to Dec 1st 1914
that I last saw her alive on Dec 1 1914
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Acute dilitation of stomach
following operation

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Abscess of liver
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. McKinnon M. D.
Dec 2 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? ....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	12/4 1914
20. UNDERTAKER	**ADDRESS**
E. M. Brown	S.P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

10 a.m.

Mrs.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 975
Registered No. 668

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ....., ... St.)
Registration District No. 78
Primary Registration District No. 2153
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Truman Love Adcitt
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1894 (Year)

7. AGE: 20 yrs. 10 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Dacota

10. NAME OF FATHER: Frank E Adcitt

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: May Butterfield

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank E Adcitt
(Address) Sand Point

15.
Filed Jan 8 1913 M M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jun 1914, to Dec 1914 that I last saw h[illegible] alive on Nov 10 1914 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M M McKinnon M. D.
Dec 3 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho
DATE OF BURIAL: 12/5 1914

20. UNDERTAKER: E M Brown.
ADDRESS: SP

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

10 Copies.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 91

Registered No. 670

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2159

2. FULL NAME Rebecca Stumberson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1838 (Year)

7. AGE: 84 yrs. 2 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Powell

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Lena Smith

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S J Burson
(Address) Sand point

15.
Filed Jan 8 1915 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3rd 1914, to Dec 3 1914
that I last saw her alive on Dec 3 1914
and that death occurred on the date stated above, at 5P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterial sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.
Dec 7 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: Dec 6 1914

20. UNDERTAKER: E M Brower — ADDRESS: Sandpoint

E M Brower

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Dec Nov.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2139
(No. ....., ... St.)

File No. .....
Registered No. 671
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Francis Marion Markham.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec 12 1848 (Month) (Day) (Year)

7. AGE: 66 yrs. 11 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ~~Canada~~ Illinois

10. NAME OF FATHER: Francis Marion Markham

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grover Markham
(Address) Lac[redacted]de Idaho

15.
Filed Jan 8 1914 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 7 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Broken Neck accidently.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W M Knapp M. D.
Dec 8 1914 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho
DATE OF BURIAL: 12/11 1914

20. UNDERTAKER: E P M Brower
ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Hope
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2183
(No. ..... , ... St.)

File No. 11
Registered No. 672
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel R Thomas

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widower

6. DATE OF BIRTH: Feb. (Month) 11 (Day) 1825 (Year)

7. AGE: 89 yrs. 10 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: unknown Thomas

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): [illegible]
(Address): Hope Ida.

15.
Filed Jan 8 1915 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1914, to Dec 22 1914, that I last saw him alive on Dec 19th 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary): Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Knapp M. D.

Dec 22 1914 (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hope | DATE OF BURIAL: Dec 24 1914

20. UNDERTAKER: E. M. Brower | ADDRESS: Sandpoint

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Vieta
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20
Primary Registration District No. 2012
(No. ....., ... St.)

File No. .....
Registered No. 7
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Elsie Lampe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 3 (Day) 1909 (Year)

7. AGE: 5 yrs. 3 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profesSsion, or particular kind of work: School girl
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Jno. Henry Lampe

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Emma Kruger

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. H Lampe
(Address) Bates Idaho

15.
Filed Dec. 14 1914 Robt W. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 13 1914, to Dec. 14 1914
that I last saw her alive on Dec. 14 1914,
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Diabetes mellitus.

(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Cardiac
(Duration) ..... yrs. ..... mos. 6 ds.
(Signed) Robt W. King M. D.
Dec. 14 1914 (Address) Vieta, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 ds. In the State 4 yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? Bates Idaho
Former or usual residence Bates Idaho

19. PLACE OF BURIAL OR REMOVAL: Bates Idaho
DATE OF BURIAL: Dec. 16 1914

20. UNDERTAKER: Rev. P. N. Schaust
ADDRESS: Squirrel, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No.
Registered No. 38

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Miss Mary Bayles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1874 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. W. Shaw
(Address) Lewiston Idaho

15.
Filed Dec. 10 – 1914
A. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Dec (Day) 5 – 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1914, to Dec 5 1914, that I last saw h alive on Dec 4 1914, and that death occured on the date stated above, at 9 00 M.

The CAUSE OF DEATH* was as follows:
Cancer Pancreas
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) 1 Yrs. 8 mos. ..... ds.

(Signed) C. W. Shaw M. D.
12/6 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. 25 days In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Orofino
Former or usual residence Orofino

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 12-8-1914

20. UNDERTAKER: L. Gasser — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 6-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 111

Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston Orchards

(No. Orchard tracts St.)

Registration District No. 95

Primary Registration District No. 1009

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Middlekrauff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 12 (Day) 1895 (Year)

7. AGE: 19 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: G. H. Middlekrauff

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Emma Ellemen

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H B Middlekrauff
(Address)

15. Filed Jan. 10 1916 L. J. Peppis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1914, to Dec 6th 1914, that I last saw her alive on Dec 6th 1914, and that death occured on the date stated above, at 1030A M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Delatation

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Myocardeal Degeneration

(Duration 3 yrs. ..... mos. ..... ds.

(Signed) A. C. Carrasco M. D.

1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 12-8-1914

20. UNDERTAKER: Carrasco — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

White 96

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 111

Registered No. 40

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. 516 Old 16th 1009 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard E Cunningz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 8 (Day) 1894 (Year)

7. AGE: 20 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo W Cunningz

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary E Donahue

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ben E Cunningz

(Address) Lewiston Idaho

15.

Filed Jan 10 1915 L.J. Perkins Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1914 to Nov 26 1914, that I last saw h. alive on Nov 26 1914, and that death occured on the date stated above, at 10-40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
& Tubercular Laryngitis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary): Some

(Duration 2 yrs. mos ds.

(Signed) Edgar L White M. D.

Dec 15 1914 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 12/15 1914

20. UNDERTAKER: L.J. Easton — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. Female

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. (C)
Registered No. 482

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 126, 18th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. December (Month) thirtieth (Day) 1849 (Year)
7. AGE: 75 Yrs. ..... Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Peoria Ill.
10. NAME OF FATHER: Joshua Bowman
11. BIRTHPLACE OF FATHER (State or Country): United States
12. MAIDEN NAME OF MOTHER: Emeline Loveland
13. BIRTHPLACE OF MOTHER (State or Country): United States.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Smith
(Address) Lewiston
15. Filed Jan 10 1915 C. C. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 22nd (Day) 1914 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 7th 1914, to Dec 22nd 1914, that I last saw her alive on 21st Dec 1914, and that death occured on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Hypertrophied cirrhosis of Liver
Chronic Interstitial Nephritis
Anasarca
(Duration), Yrs. 3 mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. M. Evans, M. D.
Dec 23 1914 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: Dec 24 1914
20. UNDERTAKER: [illegible] Dawson
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1009
File No. 1114
Registered No. 43

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 1336 F St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis E. La Rue

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 3 (Day) 14 (Year)

7. AGE ..... Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston

10. NAME OF FATHER: Frank La. Rue

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Nellie Rodgers

13. BIRTHPLACE OF MOTHER (State or Country): Pomeroy Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Harrison La Rue
(Address) Lewiston

15.
Filed Jan. 10 1915
L. J. Carter
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1914, to Dec 31 191..., that I last saw h... alive on Dec 31 191..., and that death occured on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Pneumonia Lobar

(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) C. E. Carson M. D.
19.. (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. DATE OF BURIAL: 12-31 1914

20. UNDERTAKER: C. J. Vassar ADDRESS: Lewiston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 2199
(No. ..... St.)

File No. 11
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rada McMullen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH
July (Month) 24 (Day) 1914 (Year)

7. AGE
4 yrs. 16 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L. P. McMullen

11. BIRTHPLACE OF FATHER (State or Country) S C

12. MAIDEN NAME OF MOTHER M M Wright

13. BIRTHPLACE OF MOTHER (State or Country) N C

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) L. P. McMullen Oakley Ida

15.
Filed 1-5 1915 E. D. Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. (Month) 9th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24 1914, to Dec 9th 1914, that I last saw her alive on Dec 9th 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) — yrs. — mos. 15 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Nelson M. D.
12/23 1914 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: Dec. 10 1914

20. UNDERTAKER: Thos. D. Sheets — ADDRESS: Oakley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. A 8008

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of .....

City of .....

Registration District No. .....

Primary Registration District No. .....

(No. ..... St.)

File No. 141

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. Whitaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Aug. (Month) 31 (Day) 1904 (Year)

7. AGE 10 Yrs. 4 Mos. 12 ds. IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wyoming

10. NAME OF FATHER Ira Whitaker

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary C. Sayne

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ira Whitaker
(Address) Oakley, Idaho

15.
Filed 12-17 1914 E. P. Graham
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 15th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12th 1914, to Dec. 19th 1914, that I last saw him alive on Dec. 13th 1914, and that death occured on the date stated above, at 1.50 P. M.

The CAUSE OF DEATH* was as follows:
Endocarditis with Mitral Regurgitation

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

(Duration 3 yrs. ..... mos. ..... ds.

(Signed) A. W. Gibson M. D.

12/17/1914 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Oakley — DATE OF BURIAL Dec 17 1914

20. UNDERTAKER John Gilchrist — ADDRESS Oakley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Basin
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 7194
(No. ....., ... St.)

File No. 11
Registered No. 21
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dolly Beeke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Oct. 7 (Month) (Day) 1914 (Year)

7. AGE: yrs. 2 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank C Beeke Jr

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Christina Emery

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Frank C Beeke Jr
(Address): Basin

15. Filed 12/24 1914 E. R. Shaw Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. 24 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19 1914, to Dec 23 1914, that I last saw h-r alive on Dec 23 1914, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Pertussis
Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Pertussis

(Duration) ..... yrs. ..... mos. 30 ds.

(Signed) A P Oldham M. D.

12/24 1914 (Address) Oakley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Basin	12/26 1914

20. UNDERTAKER	ADDRESS
A. Sayers	Basin Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 317
County of Twin Falls, Primary Registration District No. 1085
City of ~~Twin Falls~~ (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
File No. 11
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Sigrid M Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Sept. 23 1833 (Month) (Day) (Year)

7. AGE: 82 yrs. 3 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business, or establishment in which employed (or employer): wife

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Louis Larsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: not Known

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Twin Falls Ida
(Address): R. A. Friedrich Sons

15. Filed 12-26 1914 John Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December 24 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20 1914, to Dec 24 1914, that I last saw h alive on Dec. 23 1914, and that death occurred on the date stated above, at 9.30 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
19 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: Dec. 27 1914

20. UNDERTAKER: T. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of Twin Falls (No. ....., ... St.) Primary Registration District No. 1085
If death occurs away from usual residence, give facts called for under special information.
File No. 111
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	white	Single

6. DATE OF BIRTH: Nov. (Month) 24 (Day) 1914 (Year)

7. AGE: — yrs. 1 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Alexander Evans.

11. BIRTHPLACE OF FATHER (State or Country): Louisiana

12. MAIDEN NAME OF MOTHER: Lou Scott.

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Evans
(Address) Twin Falls

15. Filed 12-28 1914 John W. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 12 (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/26/ 1914, to 12/27/ 1914, that I last saw her alive on 12/26/ 1914, and that death occurred on the date stated above, at 11 AM.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Fry M. D.
12/28/14 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: DEC. 28 1914

20. UNDERTAKER: J. Freeman | ADDRESS: T. F.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls.
City of ((
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 11
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Martin Sharp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Married

6. DATE OF BIRTH
May 22 1875
(Month) (Day) (Year)

7. AGE
39 yrs. 7 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Mechanical D.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah. (Richmond)

10. NAME OF FATHER George Sharp.

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Mary Bair

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Benham
(Address) Twin Falls Ida

15. Filed Dec 31 1914 John Hopkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. 30 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1914, to Dec 30 — 1914, that I last saw h[illegible] alive on Dec 30 — 1914, and that death occurred on the date stated above, at 11.30 a. M.

The CAUSE OF DEATH* was as follows:
Acute Deletation of Heart following Pericarditis and Acute Myocarditis

(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Acute Rheumatism-Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.
(Signed) Duncan L. Alexander M. D.
12/31 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? Twin Falls Ida
Former or usual residence Twin Falls Ida

19. PLACE OF ~~BURIAL~~ OR REMOVAL | DATE OF BURIAL
Soda Springs Ida ..... 191..

20. UNDERTAKER | ADDRESS
C. J. Grossman | Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

27

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of ((((
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. 1085
(No. ....., ... St.)

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Swain N. Folsom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Nov. (Month) 10 (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 10 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Arthur B. Folsom

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Bertha Winner

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. B. Folsom
(Address) Twin Falls

15.
Filed 12-22 1914 Johnson Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1914, to Dec 21 1914, that I last saw him alive on Dec 20 1914, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) Transition

(Duration) ..... yrs. 1 mos. 14 ds.

(Signed) Frank A. Dwight M. D.

12-21 1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Twin Falls Ida.

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Dec 23 1914

20. UNDERTAKER: J. Grossman — ADDRESS: Twin

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of (")
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... , ... St.)

File No. " "
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James R. Cairncross

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 28 (Day) 1866 (Year)

7. AGE: 47 yrs. 11 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lmp. Dealer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: Jas. Cairncross

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Elizabeth Lindsey

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed. W. Cairncross
(Address) Twin Falls

15.
Filed Dec. 19 1914 John Hopkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1914, to Dec 19 1914, that I last saw him alive on Dec 18 1914, and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:
Appendicitis

(Duration) yrs. 3 Weeks ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Boyd M. D.
Dec 19 1914 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Burial — DATE OF BURIAL: Dec. 19 1914

20. UNDERTAKER: C. P. Grossman — ADDRESS: Twin Falls

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 1 1 1
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Byron T Mills

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 28 (Day) 1862 (Year)

7. AGE: 52 yrs. 0 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Thomas Mills

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Maggie Vaughn

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Howe Mills
(Address) Rupert Idaho

15. Filed 12-20 1914 John T. Congdon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1914, to Dec. 19 1914
that I last saw h.am alive on Dec. 19 1914
and that death occurred on the date stated above, at 11.30 M.

The CAUSE OF DEATH* was as follows:
acute Bright's Disease

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. J. B. Morgan M. D.
12/20 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Dec. 21 1914

20. UNDERTAKER: C. J. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 4
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kyle Dow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Sept (Month) 26 (Day) 1913 (Year)

7. AGE: 1 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: Geo M Dow

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Etta Gray

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Geo. M. Dow
(Address): Twin Falls Idaho

15. Filed Dec 21 1914 — Jabez H Houghton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914, to Dec 21 1914, that I last saw h alive on Dec 21 1914, and that death occured on the date stated above, at 5 45 P. M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration yrs. 1 mos. ds.

(Signed) H W Wilson M. D.

12-22 1914 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 12-23 1914

20. UNDERTAKER: B Marsh — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of 11 11
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sophia E. Warrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widowed

6. DATE OF BIRTH: March 18 1847 (Month) (Day) (Year)

7. AGE: 67 yrs. 9 mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Joseph Edmundson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Kinnard

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jessie Warrington
(Address) Twin Falls

15. Filed 1-2-20 1915 John T. Congleton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. 18 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28 1914, to Dec 17 1914, that I last saw her alive on Dec. 17 1914 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. O'Brien M. D.
Dec 21 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Dec. 21 1914

20. UNDERTAKER: C. J. Goodrich — ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)
Registration District No. 37
Primary Registration District No. 1085
File No. 11
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carline Vera

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 03 (Day) 1914 (Year)

7. AGE: ..... Yrs. 9 Mos. 03 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: R. W. Vera

11. BIRTHPLACE OF FATHER (State or Country): Ia.

12. MAIDEN NAME OF MOTHER: Ethel Jarvis

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. W. Vera
(Address) Twin Falls Ida

15. Filed 12-16 1914 — John Kingsbury, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1914 to Dec 16 1914, that I last saw her alive on Dec 16 1914, and that death occured on the date stated above, at 7:35 M.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Cerebro Spinal Meningetis
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) D. W. Hixon M.D.
12/16 1914 (Address) Twin Falls Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 12-17 1914

20. UNDERTAKER: Marsh — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of [illegible]
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Wm. Runyon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Aug. (Month) 9 (Day) 1854 (Year)

7. AGE: 60 yrs. 4 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or establishment in which employed (or employer): Investor

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Philip Runyon

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. John W. Runyon
(Address) Twin Falls

15. Filed 12-13 1914 John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 12 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/10/1914, to 12/12/1914, that I last saw him alive on 12/11/1914, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Paralysis (Cerebral Hemorrhage)

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. F. Pike M. D.
12/13/1914 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Dec. 13 1914

20. UNDERTAKER: J. Goodman — ADDRESS: [illegible]

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of [illegible]
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1085
(No. , St.)

File No.
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William L Snodgrass

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 14 (Day) 1905 (Year)

7. AGE: 9 yrs. 3 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry business, or datablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: W. L. Snodgrass.

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Grace Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Snodgrass
(Address) Twin Falls Ida.

15.
Filed 12-12 1914 John D. Coughlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1914, to Dec. 11 1914
that I last saw him alive on Dec 11 1914
and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(Duration) yrs. 1 mos. - ds.
Contributory (Secondary) Acebro Spinal Meningites
(Duration) yrs. - mos. 14 ds.

(Signed) A. W. Wilson M. D.
Dec 14 1914 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Dec 14 1914

20. UNDERTAKER: J. F. Sonaman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of 11 11
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 9781
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary J. Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
Jan. (Month) 27 (Day) 1850 (Year)

7. AGE
64 yrs. 10 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housekeeping
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indiana.

10. NAME OF FATHER Harris

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER Lilly Morgan.

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Reed
(Address) Buhl Ida.

15.
Filed Dec. 10 1914 John V. Eagleson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
December (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1914, to Dec 9 1914, that I last saw h[illegible] alive on Dec 9 1914 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 9 ds.
Contributory (Secondary) Arteriosclerosis
(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) F. O. Boyd M. D.
Dec 11 1914 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL North Yakima Wash. | DATE OF BURIAL Dec. 10 1914

20. UNDERTAKER O. H. Grossman | ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. ____
Registered No. ____

1. PLACE OF DEATH.
County of Twin Falls
City of "

(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph R Jones

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 5 (Day) 1882 (Year)

7. AGE: 32 Yrs. 3 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sec Warehouse
(b) General nature of industry, business, or establishment in which employed (or employer): foreman

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W J Leslie
(Address) Twin Falls Ida

15. Filed 12-10 1914 John H Coughlin Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 8th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Instant death while at work.
Caused by Heart block.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Corobonnum - Aurieles thin as paper + covered with dark leathery Congulum
(Signed) J. R. Morgan M. D.
12/8 1914 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Franklin Penn
DATE OF BURIAL: — 1914

20. UNDERTAKER: D Marsh
ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai — Registration District No. 32 — File No. 91

City of St Maries — Primary Registration District No. 2049 — Registered No.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clifford R Porter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) 27 (Day) 1914 (Year)

7. AGE: ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Maries

10. NAME OF FATHER: Preston Porter

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: May Allbery

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Preston Porter

(Address) St Maries

15. Filed Dec. 31 1914 — H. L. Mukeahy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1914, to Dec 31 1914, that I last saw him alive on Dec 30 1914, and that death occured on the date stated above, at 12:50 M.

The CAUSE OF DEATH* was as follows:

Due to Birth injuries received from Lodged Labor.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R H Mac Rae M. D.

1/1 1915 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Dec. 31 1914

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 9784
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna A. Thornes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F. M.	White	Married

6. DATE OF BIRTH
Aug. (Month) 13 (Day) 1853 (Year)

7. AGE
61 yrs. 4 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Ida.

10. NAME OF FATHER
" "

11. BIRTHPLACE OF FATHER
(State or Country) " "

12. MAIDEN NAME OF MOTHER
" "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bertha Yeager
(Address) St John Idaho

15.
Filed Dec. 30 1914 H. L. Mulkey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 28 1914., to Dec 30 1914, that I last saw h.. alive on Dec. 30 1914, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Internal Hemorrhage from rupture of blood vessels.
(Duration) ..... yrs. ..... mos. 10 minutes ds.
Contributory (Secondary) Hardening of blood vessels & Epilepsy.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Kinnaburg M. D.
1730 1914 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Jan 4 1915

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Near Pedee

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

2. FULL NAME C E Plunkitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 7 (Day) 1880 (Year)

7. AGE: 34 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer in woods

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Johns Switch, Ind

10. NAME OF FATHER John Plunkitt

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Missouria Maple

13. BIRTHPLACE OF MOTHER (State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. H. Plunkitt

(Address) 3304 E Fairview Spokane

15. Filed Dec 2 1914 H. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914, to Dec 1 1914, that I last saw h— alive on Dec 1 1914 and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Gun shot wound from 30 30 bullet

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gun shot wound

Fractured Femur (Duration — yrs. — mos. — ds.

(Signed) W. D. Keeton act. Coroner M. D.

12/2 1914 (Address) Stevens Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane — DATE OF BURIAL 191

20. UNDERTAKER: H. L. Mulcahy — ADDRESS Spokane

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 11
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna J. Grice

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan. (Month) 18 (Day) 1848 (Year)

7. AGE: 66 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Stevens Barnaby

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: D K

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C L Grice
(Address) Avery Idaho.

15. Filed Dec 4 1914 H L Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1914, to Dec 4 1914, that I last saw her alive on Dec 4 1914, and that death occured on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:
Emphysema of gall bladder

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Acute attack

(Duration 15 yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
Dec 4 1914 (Address) Avery Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chicago, Ills. DATE OF BURIAL ..... 191...

20. UNDERTAKER: H L Mulcahy ADDRESS St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

File No. 14

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilmer Toohey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) (Day) 1910 (Year)

7. AGE: 4 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mont.

10. NAME OF FATHER Wm Toohey

11. BIRTHPLACE OF FATHER (State or Country) Ire.

12. MAIDEN NAME OF MOTHER Ida Boley

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Toohey

(Address) St Maries

15. Filed Dec 11 1914

H. L. Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1914, to Dec 11 1914, that I last saw him alive on Dec 11 1914, and that death occured on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows: Gleo Colitis. (Cholera Infantum)

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Derk D. Platt M. D.

Dec 11 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Dec. 13 1914

20. UNDERTAKER: H L Mulcahy — ADDRESS: St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11

Registered No. .....

Registration District No. 39

Primary Registration District No. 2049

1. PLACE OF DEATH.

County of Kootenai

City of St Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ward George Burnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 4 (Day) 1865 (Year)

7. AGE: 49 Yrs. 5 Mos. 7 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER S Burnett

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Nancy Mansfield

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edna Pyarley
(Address) Seattle

15. Filed Dec. 11 1914 H. L. Mahaffey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914, to Dec 11 1914, that I last saw him alive on Dec 11 1914, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Hemmorhage from stomach and bowels

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Obstruction of gall bladder

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) Orin D. Platt M. D.
Dec 12 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Dec. 16 1914

UNDERTAKER: H. E. Eastman — ADDRESS: St M.

SYMS - YORK CO., PTRS. & ENGS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

County of Kootenai

City of St Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lincoln A Chamberlain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. 7 (Month) 19 (Day) 1850 (Year)

7. AGE: 64 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Luther Chamberlain

11. BIRTHPLACE OF FATHER (State or Country): Washington D C.

12. MAIDEN NAME OF MOTHER: Martha Paterson

13. BIRTHPLACE OF MOTHER (State or Country): Washington D C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C S Chamberlain

(Address) St Maries

15. Filed Dec. 15 1914 H. L. Medcalf Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1914, to Dec 14 1914, that I last saw h[illegible] alive on Dec 14 1914, and that death occured on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

Third attack

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen D. Platt M. D.

Dec 14 1914 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Dec. 16 1914

20. UNDERTAKER: H Eastment — ADDRESS: St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1[illegible]

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Melrose

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 93

Primary Registration District No. 2178

(No. ....., ... St.)

2. FULL NAME John T. Steele

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 12 (Month) - 20 (Day) - 1842 (Year)

7. AGE: 72 Yrs. 10 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Wm Steele

11. BIRTHPLACE OF FATHER (State or Country): V

12. MAIDEN NAME OF MOTHER: Nancy Wallace

13. BIRTHPLACE OF MOTHER (State or Country): V

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hugh S Steele
(Address) Melrose

15. Filed 11-14 1914 J. M. Fyle
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1[illegible] (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Phys. 191.. to ..... 191....., that I last saw h[illegible] alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Paralysis agitans

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Angel Ridge — DATE OF BURIAL: 10-10 1914

20. UNDERTAKER: none — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2132
File No. 170
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Paris
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carol Longhurst.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Dec. (Month) 14 (Day) 1914 (Year)

7. AGE
..... Yrs. ..... Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Paris Ida.

10. NAME OF FATHER
Charles Longhurst.

11. BIRTHPLACE OF FATHER
(State or Country) Garden City

12. MAIDEN NAME OF MOTHER
Margret Bryson

13. BIRTHPLACE OF MOTHER
(State or Country) Woodruf Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Char. D. Longhurst.
(Address) Border Ida.

15.
Filed 12-28-1914
T. J. Sutton
Local Registrar

SYMS - YORK CO., PTRS. & SHRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1914, to Dec 26 1914, that I last saw her alive on Dec 26 1914, and that death occured on the date stated above, at 12. A M.

The CAUSE OF DEATH* was as follows:
Pneumonia.

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. J. Sutton M. D.
Dec 26 1914 (Address) Paris Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Ida. DATE OF BURIAL: Dec 27 1914

20. UNDERTAKER: Mrs. W. Cook. ADDRESS: Paris Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 53

Primary Registration District No. 2132

File No. 14

County of Bear Lake

City of Bloomington (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Ann Aland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	widowed

6. DATE OF BIRTH

July (Month) 2 (Day) 1853 (Year)

7. AGE

61 yrs. 5 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER James Holmes

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Hart

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) LeRoy Hill

(Address) Bloomington

15.

Filed 12-28-1914 J. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec (Month) 17 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1914, to Dec 17 1914, that I last saw her alive on Dec 17 1914, and that death occurred on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage intestinal
following dysentery

(Duration) 0 yrs. 0 mos. 2 ds.

Contributory (Secondary) nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Lt A Hottendorf M. D.

Dec 18 1914 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Bloomington — DATE OF BURIAL Dec 19 1914

20. UNDERTAKER J. Jacobsen — ADDRESS Bloomington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Paris
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53
Primary Registration District No. 2192
(No. ....., ... St.)

File No. 170
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cuvila Lane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W.	Single

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1914 (Year)

7. AGE: ..... yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .... Baby
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bear Lake

10. NAME OF FATHER Jesse Lane

11. BIRTHPLACE OF FATHER (State or Country) Paris Idaho

12. MAIDEN NAME OF MOTHER Cinda Pierpoint

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse Lane
(Address) .....

15. Filed 12-12-1914 R. J. Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 2 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1914 to Dec 2 1914, that I last saw h alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Paul Pneumonia
Bronchial Pneumonia
.....
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Beasley M. D.
10 Dec 1914 (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Paris Ida	10 Dec 3 1914

20. UNDERTAKER	ADDRESS
Fisher Ashley	Paris Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai — Registration District No. 29.

City of Coeur d'Alene — Primary Registration District No. [illegible] — File No. 3179

(No. ....., ... St.) — Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Witt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1848 (Year)

7. AGE

67 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country) Germany

10. NAME OF FATHER

—

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Mary Dorn

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul H Witt

(Address) 981 Government Way

15. Filed Dec. 14 1914 W. McSolund Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1912 1912, to Dec 10 1914, that I last saw h[illegible] alive on Dec 10 1914, and that death occured on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) General dropsy

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Buckley M. D.

19..... (Address) Coeur D'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: Dec 16 1914

20. UNDERTAKER: D J Luer — ADDRESS: C D A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 3[illegible]
Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Helen Olson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Sept (Month) 10 (Day) 1881 (Year)

7. AGE: 33 yrs. 3 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: P. A. Peterson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Olson
(Address) .....

15. Filed Dec 15 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1914, to Dec 12 1914 that I last saw h[illegible] alive on Dec 12 1914 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia - Left Lobar.

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
12/15/1914 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary
DATE OF BURIAL: Dec 18 1914

20. UNDERTAKER: Cassedy & Nelson
ADDRESS: Coeur D'Alene

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1058

File No. 31

Registered No. 23

County of Kootenai

City of Coeur d Alene (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Swinney Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 4 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J W Reed

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Bernice Silyeums

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J W Reed

(Address) C d A

15. Filed Dec. 8 1914 M. A. Holland Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Dec. 4 1914, that I last saw h[illegible] alive on Dec. 4 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cause not determined

.....(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Wagner M. D.

Dec 7 1914 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	Dec 8 1914
20. UNDERTAKER	**ADDRESS**
S J Quinn	C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Post-Falls (No. ....., ... St.)
File No. 3 976
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kathryn Virginia Shields

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 9 (Month) 25 (Day) 1914 (Year)

7. AGE: ..... yrs. 2 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Post Falls

10. NAME OF FATHER: Frank S Fields

11. BIRTHPLACE OF FATHER (State or Country): Iowa. Wis.

12. MAIDEN NAME OF MOTHER: Anna Carter

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. H. Shields,
(Address) .....

15. Filed Dec 26 1914 Maddaford
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 19 1914, to Dec. 23 1914
that I last saw h[illegible] alive on Dec 23 1914
and that death occurred on the date stated above, at 11.15 M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.
Contributory Cerebro-spinal Meningitis
(Secondary)
..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) B F Campbell M. D.
Dec. 24 1914 (Address) Post Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Evergreen
DATE OF BURIAL: Dec 26 1914

20. UNDERTAKER: Cassedy & Nelson
ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5 25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1650
File No. 29799
Registered No. 26

1. PLACE OF DEATH.
County of Kootenai
City of C. d A. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Gellett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1842 (Year)

7. AGE: 72 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Lyman

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Eugene Gellett
(Address) C d A

15. Filed Dec 24 1914 W. A. Poland Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1912, to Dec 23 1914, that I last saw h[illegible] alive on Dec 10 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Interstitial Nephritis

(Duration) — Yrs. 3 mos. — ds.

Contributory (Secondary) .....
(Duration — yrs. — mos. — ds.

(Signed) W. H. Haeberlin M. D.
12/23 1914 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest View — DATE OF BURIAL: Dec 26 1914

20. UNDERTAKER: D. J. Lucas — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 3 [illegible]
Registered No. 27

1. PLACE OF DEATH.
County of Kootenai
City of C d A
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Chrisman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	widow

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1840 (Year)

7. AGE
74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER John Smith

11. BIRTHPLACE OF FATHER
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Fuller
(Address) Coeur d Alene

15.
Filed Dec 22 1914 M E Copeland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 21st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Dec 1914, that I last saw her alive on Dec 19 1914, and that death occured on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:
General Dropsy
due to Chronic
Bright's

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
.....(Duration 2 yrs. — mos. — ds.

(Signed) Jno Busby M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	Dec 23 1914
20. UNDERTAKER	ADDRESS
S J Lee	C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 50
(No. , St.)

File No. 39801
Registered No. 28
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Buckley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH
June (Month) 17th (Day) 1849 (Year)

7. AGE
66 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Fruit Unspector
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Wm Buckley

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. A. Buckley
(Address) Pullman Wash.

15. Filed Dec 31 1914 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1914, to Dec 30 1914, that I last saw him alive on Dec 29 1914, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Phthisis

(Duration) yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Dec 31 1914 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Jan. 1st 1915
20. UNDERTAKER	ADDRESS
T. E. Riddell	C.D.A.

SYMS - YORK CO., PTRS. & BORS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 9802
Registered No. 29

1. PLACE OF DEATH. Registration District No. 29
County of Bonlenaci Primary Registration District No. 1050
City of Garwood C.D.A. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bell Robson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1889 (Year)

7. AGE: 25 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Louis Plumodore

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Desatell

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lamar Pond
(Address) .....

15. Filed Dec 26 1914 W. A. Rowland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw h... alive on — 191...
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Gun shot wound of Chest.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Spokane Wash
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Gus Nelson
ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Bancroft
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048
(No. ....., ... St.)

File No. 9803
Registered No. 45

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Lasley Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: w
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec. 5 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Lasley

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Carrie Muir

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm Lasley
(Address): Bancroft, Ida.

15.
Filed Dec 10, 1914 Chas Kasey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 6 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1914, to Dec 6 1914, that I last saw h— alive on Dec 5 1914 and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

asthenia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. J. Smith M. D.

Dec 14 1914 (Address) Bancroft Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bancroft — DATE OF BURIAL: Dec 6 1914

20. UNDERTAKER: H. C. Johnson — ADDRESS: Bancroft

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 69
Primary Registration District No. 2147
File No. 9805
Registered No. .....

1. PLACE OF DEATH.
County of Bingham
City of Shelley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lafayette B. Hampton,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 23 (Day) 1886 ~~XIXX~~ (Year)

7. AGE: 28 Yrs. 5 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: City Marshall
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ogden, Utah.

10. NAME OF FATHER: Eddley F. Hampton

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Emma Pons

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leon Hampton
(Address) Shelley, Idaho.

15. Filed 11—28 1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

A Gun shot wound in left eye
fired by parties unknowen by us
but supposed by evidence to have been
fired by one of three mexicans whom
he was persuing endeavoring to arrest
(Duration) ..... yrs. ..... mos. ..... ds.

~~Contributory~~ (Secondary) Abrasion on Left L. coroners jury's verdict
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Peck Coroner M. D.
19.... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley, Idaho.
DATE OF BURIAL: 11/19/ 191 4

20. UNDERTAKER: C. E. Dinwoodey
ADDRESS: Ida. Falls

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 69
Primary Registration District No. 2147
(No. .... St.)

File No. 9806
Registered No. .....

1. PLACE OF DEATH.
County of Bingham
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otto Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
April (Month) 18 (Day) 1878 (Year)

7. AGE
16 Yrs. 7 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Denmark

10. NAME OF FATHER: Jens Petersen

11. BIRTHPLACE OF FATHER
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER: Nikolina Christiansen

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jens Petersen by E.E.D.
(Address) Shelley Ida

15.
Filed 9-27 1914 Edwin Cutler
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1914, to Sept 26 1914, that I last saw h— alive on Sept 26 1914, and that death occured on the date stated above, at 3:30a M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... Yrs. ..... mos. 2½ ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Dunwoody M. D.

Sept 26 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Goshen, Ida — DATE OF BURIAL: 9/27 1914

20. UNDERTAKER: E E Dunwoody — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 69
Primary Registration District No. 2147
File No. 1811
Registered No. .....

1. PLACE OF DEATH.
County of Bingham
City of Goshen (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera Holm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 20 (Day) 1914 (Year)

7. AGE: ....Yrs. 2 Mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Goshen Bingham Co

10. NAME OF FATHER: Alma Holm

11. BIRTHPLACE OF FATHER (State or Country): Hyrum Utah

12. MAIDEN NAME OF MOTHER: M. Nielsen

13. BIRTHPLACE OF MOTHER (State or Country): Goshen Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dwight Henry
(Address) Idaho Falls

15. Filed 10-6 1914 Edwin Carter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1914, to Oct 4 1914, that I last saw h[illegible] alive on Oct 4 — 1914, and that death occured on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Premature birth

(Duration) ..... yrs. 2 mos. 14 ds.
(Signed) Edwin Carter M. D.
10-5 1914 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Goshen Cemetery — DATE OF BURIAL: 10-5 1914

20. UNDERTAKER: Dwight Henry — ADDRESS: Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

AMERICAN TRUSTED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Goshen
Registration District No. 73
Primary Registration District No. 2150
(No. ....., ... St.)
File No. 1[illegible]
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Verna Holm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 20 (Day) 1914 (Year)

7. AGE: ..... Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Goshen

10. NAME OF FATHER: Alma Holm

11. BIRTHPLACE OF FATHER (State or Country): Hyrum Utah

12. MAIDEN NAME OF MOTHER: M. Nielsen

13. BIRTHPLACE OF MOTHER (State or Country): Hyrum Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dwight Henry
(Address) Idaho Falls

15. Filed Oct 6 1914
Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Oct 3 1914, that I last saw her alive on Oct 3 1914, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Marasmus
(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Premature birth
(Duration) ..... yrs. 2 mos. 13 ds.
(Signed) Edwin Cutler M. D.
10-5 19.... (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Goshen Cemetery — DATE OF BURIAL: 10-5 1914
20. UNDERTAKER: Dwight Henry — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of Taylorville
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec 29, 1914 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William C. Thomas

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Amelia Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) William Thomas

15. Filed 12-28 1914 Edwin Cutler Local Registrar

6YMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 29, 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Taylorville — DATE OF BURIAL: 12-28 1914

20. UNDERTAKER: J. H. Hunt. — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9811

Registered No.

1. PLACE OF DEATH.
County of Bingham
City of Shelley Ida.

Registration District No. 69
Primary Registration District No. 2147
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Lucille Partridge

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug – 8 – 1914 (Month) (Day) (Year)

7. AGE: yrs. 1 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley Idaho

10. NAME OF FATHER: Ray Partridge

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Velera Terry

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Partridge
(Address) Shelley Idaho

15. Filed 10/2/1914 Edwin Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 – 1 – 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10 – 1 – 1914, to 10 – 1 – 1914 that I last saw her alive on 10 – 1 – 1914 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(Duration) yrs. + mos. 7 days

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. B. Jones M. D.

10-2 1914 (Address) Shelley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery — DATE OF BURIAL: 10-2-1914

20. UNDERTAKER: Stone — ADDRESS:

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Canyon

Primary Registration District No. 2006

File No. 451

City of Near Nampa (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Hodkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Dont know (Month) (Day) (Year)

7. AGE: 82 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Robt Hodkinson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. J Hodkinson

(Address) .....

15. Filed Dec 24 1914 Dr S D Colony Local Registrar

Ruth Hoffman Deputy Reg Robinson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1914, to Dec 23 1914, that I last saw him alive on Dec 21 1914, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(Duration) — Yrs. 3 mos. — ds.

Contributory (Secondary) Do not Know

(Duration) — yrs. ..... mos. ..... ds.

(Signed) D Forney M. D.

12/24, 1914 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	12-24 1914
20. UNDERTAKER	**ADDRESS**
Nampa	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 981
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hugh Johnson McCain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH. Oct. (Month) 8 (Day) 1844 (Year)

7. AGE 66 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tenn

10. NAME OF FATHER Alexander L. McCain

11. BIRTHPLACE OF FATHER (State or Country) N. C.

12. MAIDEN NAME OF MOTHER McQuiston

13. BIRTHPLACE OF MOTHER (State or Country) N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. C. McCain
(Address) Nampa Ida

15. Filed Jan 2 1915 S D Coleman Local Registrar
Mrs Katherine Robinson Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1914 to ..... 191....,
that I last saw h..... alive on ..... 191....,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Fell over while at work & died at once - Had had some trouble with heart. Was dead when I arrived
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Had some Rheumatism
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O H Murray M. D.
Dec 31 1914 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Nampa Ida — DATE OF BURIAL Jan 2 1914

20. UNDERTAKER E. E. Robinson — ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 151
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Mary Robertson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucassian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October (Month) 6 (Day) 1914 (Year)

7. AGE: Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canyon County, Idaho

10. NAME OF FATHER E. B. Robertson

11. BIRTHPLACE OF FATHER (State or Country) Brown County, Kansas

12. MAIDEN NAME OF MOTHER Donna Morrill Irvin

13. BIRTHPLACE OF MOTHER (State or Country) Brown County, Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E B Robertson
(Address) 711-2nd St. S. Nampa Idaho.

15. Filed Dec 23 1914 Dr S D Calonge Local Registrar
Anna Layfield Deputy 77 Robinson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h~~e~~ alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Child seemed healthy and took its bottle at 1 30 a.m. went to sleep & was discovered dead at 8 a.m. Cause unknown but I pronounce Cerebro (Duration) spinal meningitis 1 month 2 weeks mos. 4 days ds.
Contributory (Secondary) death due to strangulation
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H. P. Ross M. D.
Dec 27 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 12-23 1914

20. UNDERTAKER — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24052

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. (1917)

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Near Nampa (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 6 (Day) 1896 (Year)

7. AGE: 18 Yrs. 10 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work, Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER C Russell

11. BIRTHPLACE OF FATHER (State or Country) N C

12. MAIDEN NAME OF MOTHER Nancy Land

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O R Russell
(Address) .....

15. Filed Dec 21 1917 Dr S D Calonge Local Registrar
Ruth Hatfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Dec 16 1914, that I last saw her alive on Dec 16 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H P Rees M. D.
Dec 21 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days In the State .....yrs .....mos .....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	12-21 1917
20. UNDERTAKER	ADDRESS
F T Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - VOSE CO., PTRS. & BKBS. 24-0825

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

File No. 171

County of Canyon

City of Near Nampa (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Botts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 16 (Day) 1847 (Year)

7. AGE: 67 Yrs. 11 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER: Benjamin Botts

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER: Martha Lincoln

13. BIRTHPLACE OF MOTHER (State or Country) D.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. R. Botts

(Address) Caldwell Ida RFD

15. Filed Dec 18 1914 Dr S D Calonge Local Registrar

Deputy

SVMS - YORK CO., PTRS. & BDRS. 24652

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Dec (Day) 11 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11. 10:30 AM 1914, to Dec 11 11:15 am 1914, that I last saw him alive on Dec 11 1914, and that death occured on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes.

(Duration) 1 Yrs. 8 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Bravo R Payne M. D.

19 .... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. ..... mos. ..... days. In the State 5 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Cancer not say

Former or usual residence Iowa & Mo

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: 12-18 1914

20. UNDERTAKER: Robinson — ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 1006

File No. 151

Registered No. .....

County of Canyon

City of Nampa (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Emma DeCoursey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 6 (Day) 1855 (Year)

7. AGE: 59 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ind

10. NAME OF FATHER Jas Price

11. BIRTHPLACE OF FATHER (State or Country) Indiana Kentucky

12. MAIDEN NAME OF MOTHER Nancy Bryant

13. BIRTHPLACE OF MOTHER (State or Country) Vermont Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J M DeCoursey

(Address) Nampa Ida

15. Filed Dec 16 1914 W S O Colonge Local Registrar

Asst Deputy Ref I Robinson

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1914, to ..... 191..., that I last saw her alive on Nov 1 1914, and that death occured on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 7 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P L Payne M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 6 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ..... Nmd .....

Former or usual residence ..... Nmd .....

19. PLACE OF BURIAL OR REMOVAL: Fairview Cemetery — DATE OF BURIAL: 12-16 1914

20. UNDERTAKER: ..... — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1-1

Registered No.

PLACE OF DEATH.

County of Latah

City of Juliaetta

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH Jan (Month) 8 (Day) 1854 (Year)

7. AGE 60 yrs. 10 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER Matthew L Ward

11. BIRTHPLACE OF FATHER (State or Country) West Va

12. MAIDEN NAME OF MOTHER Amanda White

13. BIRTHPLACE OF MOTHER (State or Country) West Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amanda Alexander

(Address) Juliaetta Idaho

15.

Filed Jany 2 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 11 A.M. 1914, to Nov 21 1 P.M. 1914 that I last saw her alive on Nov 21, 1 P.M. 1914 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Rothwell M. D.

Dec 31 1914 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.

In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cameron Idaho

DATE OF BURIAL ..... 191...

20. UNDERTAKER R. H. Porter

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 50
Primary Registration District No. 2129
(No. ..... St.)

File No. 1[illegible]
Registered No. 23

1. PLACE OF DEATH.
County of Genesee
City of Ilo

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
11 (Month) 30 (Day) 1914 (Year)

7. AGE
..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Idaho. Ilo

10. NAME OF FATHER: Albert M. Alexander

11. BIRTHPLACE OF FATHER
(State or Country) N. C.

12. MAIDEN NAME OF MOTHER: Hattie I Gillespie

13. BIRTHPLACE OF MOTHER
(State or Country) N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. M. Alexander
(Address) Ilo Idaho

15.
Filed 12-4 1914
R. C. Parrish
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-30 1914, to 12-4 1914, that I last saw her alive on 12-4 1914, and that death occured on the date stated above, at 2-a-M.

The CAUSE OF DEATH* was as follows:
Fatty degeneration of the Newly born

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) R. C. Parrish M. D.
12-4 1914 (Address) Ilo Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ilo. I.O.O.F.
DATE OF BURIAL: 12-4 1914

20. UNDERTAKER: Star Eden + Swift Co
ADDRESS: Ilo Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 9822
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edgar Rasmussen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: aug (Month) 7 (Day) 1887 (Year)

7. AGE: 27 yrs. 2 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bloomington

10. NAME OF FATHER: N P Rasmussen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Josephine Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Thompson
(Address) Bloomington

15. Filed 1/91 1915 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Oct 14 1914, that I last saw h alive on Oct 14 1913 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo F Shields M. D.

Oct 14 1914 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington — DATE OF BURIAL: Oct 15 1914

20. UNDERTAKER: Peter Thompson — ADDRESS: Bloomington Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 952

Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Fireda Audrey Burbangh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 10 (Month) 25 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 56 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Dau of Child
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kamiah

10. NAME OF FATHER: Earl Burbangh

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Lillett Lisley

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Burbangh
(Address) Kamiah

15.
Filed 12/22 1914 W. F. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-25 1914, to 12-20 1914 that I last saw her alive on Dec. 7th 1914, and that death occurred on the date stated above, at 5:50 A.M.

The CAUSE OF DEATH* was as follows:
Not known. Child died suddenly. Had a little cold but was apparently as well as usual until a few minutes before death.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) 2 other children have died same way. Post Mort refused.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. F. McMahan M. D.
12/21 1914 (Address) Kamiah.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemt. | DATE OF BURIAL: 12/22 1914

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 49

Primary Registration District No. 2128

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9826

Registered No.

1. PLACE OF DEATH.

County of Lewis E

City of Kamiah (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	White	Widowed

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1834 (Year)

7. AGE: 80 yrs. 1 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house keeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Tiffton

11. BIRTHPLACE OF FATHER (State or Country): dont know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. W. Young
(Address) Kamiah

15. Filed 12/13 1914 W. D. McMahan, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 12 (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15th. 1913, to Dec. 12th. 1914, that I last saw her alive on 11 12th. 1914, and that death occurred on the date stated above, at 3:20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vulva

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. McMahan M. D.

12/12 1914 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
IOOF Cemt.	12/13 1914

20. UNDERTAKER	ADDRESS
C. J. Johnson	Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Woodland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2128
(No. ....., ... St.)
File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Enula Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
Feb (Month) 17 (Day) 1914 (Year)

7. AGE
..... yrs. 10 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Child
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Washington

10. NAME OF FATHER Frank Roberts

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mary Finney

13. BIRTHPLACE OF MOTHER
(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Finney
(Address) Woodland Idaho

15.
Filed 12/31 1914 W. H. McMahon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1914, to alive 191 , that I last saw h.. alive on Dec 30 1914, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Brown M. D.
12/30 1914 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodland, Ida	12/31 1914

20. UNDERTAKER	ADDRESS
O. J. Johnson	Kamiah Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5-1
Primary Registration District No. 2130
(No. ....., ... St.)

File No. 1
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roy Stites

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: March 24 1914
(Month) (Day) (Year)

7. AGE: ..... yrs. 8 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Custer Co Oklahoma

10. NAME OF FATHER: William H Stites

11. BIRTHPLACE OF FATHER (State or Country): Nemaha Co Nebr.

12. MAIDEN NAME OF MOTHER: Emma Maud Estabrook

13. BIRTHPLACE OF MOTHER (State or Country): Cass Co Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William H Stites
(Address) Payette Ida

15. Filed Jan 10th 1915 Crispin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1914, to Dec 18 1914, that I last saw him alive on Dec 18 1914 and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Hay M. D.
12/24 1914 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: Dec 19 1914

20. UNDERTAKER: J. H. Adair | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 157

Registered No. 5

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of ..... (No. ....., ... St.)

Registration District No. 31
Primary Registration District No. 2130

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ina A Lois Carter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 14 (Day) 1887 (Year)

7. AGE: 27 yrs. 5 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: N. H. Carter

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Ina A Canfield

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. H. Carter
(Address) New Plymouth R. D. #1

15.
Filed Jan. 10 1915. Crispin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 0 191..., to 0 1914
that I last saw her alive on Never 1914
and that death occurred on the date stated above, at 2 30 P M.

The CAUSE OF DEATH* was as follows:
Patient was crippled with some sort of rheumatism and heart trouble

(Duration) 27 yrs. ..... mos. ..... ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jacob Brumbaugh M. D.
19..... (Address) Ontario Ore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ontario, Ore
DATE OF BURIAL: Dec. 12 1914.

20. UNDERTAKER: L. Tuttle
ADDRESS: Ontario Ore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai — Registration District No. 226

City of Harrison — Primary Registration District No. 2204

(No. ..... St.)

File No. .....

Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Bakken

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. November (Month) 26 (Day) 1846 (Year)

7. AGE: 49 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Peter Bakken

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Mary Thinge

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) + Mrs. N. P. Madison
(Address) Rockford Un. P. #1 Box 3

15. Filed Jan 7 1915 — R S Jensen, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 191.., to Nov 24 1914, that I last saw him alive on Nov 24 1914 and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) O. L. Peer M. D.

19..... (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: 11-26 1914

20. UNDERTAKER: E. W. Wheeler — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SMITH-YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

File No. .....
Registered No. 93

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept (Month) 8 (Day) 1851 (Year)

7. AGE: 63 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: John B. Draper

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Caroline Britton

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Young
(Address) Harrison

15.
Filed Jan 7 1915
R S Jensen
Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1914, to Dec 6 1914,
that I last saw h.r alive on Dec 6 1914,
and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Bronchio-pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) E. D. Pague M. D.
19..... (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: Dec 9 1914

20. UNDERTAKER: Evan Thelin — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. (1)

Registered No. 32

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Josephine Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 28th (Day) 1873 (Year)

7. AGE: 41 yrs. 6 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: John. Harman

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mrs Geo Brigham

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Smith
(Address) Harrison Ida.

15.
Filed Jan 7 1915 — R S Jensen, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1914, to Dec 7 1914
that I last saw her alive on Dec 7 1914
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach.

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Cannon M. D.
Dec 8 1914 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: Dec 10 1914

20. UNDERTAKER: E M Carlson — ADDRESS: Harrison

STEIS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. 31

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

Registration District No. 126

Primary Registration District No. 9204

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Steven Henry Burns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 7 (Day) 1914 (Year)

7. AGE: ....Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Fred Burns

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Mary J. Marbett

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Burns

(Address) Harrison

15. Filed Jan 7 1915 R S Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1914, to Dec 25 1914, that I last saw h[illegible] alive on Dec 25 1914, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration) .....Yrs. .....mos. .....ds.

(Signed) E. L. Wheeler M. D.

.....19..... (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: Dec 26 1914

20. UNDERTAKER: E. W. Wheeler — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24853

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

File No. 1[illegible]
Registered No. 90

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margrete Knudsen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 17 (Day) 1848 (Year)

7. AGE: 66 yrs. 5 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Telemarken Norway

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Knudsen
(Address) Harrison

15.
Filed Jan 7 1915 — R S Jensen, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1914, to Dec 10 1914
that I last saw her alive on Nov 2 1914
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Endo carditis

(Duration) 20 yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Tenney M. D.
Dec 12 1914 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison Cemetery
DATE OF BURIAL: 12/-13 1914

20. UNDERTAKER: E W Keeler
ADDRESS: Harrison Ida

STORY-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 126
County of Kootenai Primary Registration District No. 2209
City of Harrison (No. ....., ... St.)
File No. 1
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George John Smith.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: March 24 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. 9 mos. 7 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Harrison Ida.

10. NAME OF FATHER Frank Smith

11. BIRTHPLACE OF FATHER Wisconsin (State or Country)

12. MAIDEN NAME OF MOTHER Lula Richardson

13. BIRTHPLACE OF MOTHER Oklahoma. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Smith.
(Address) Harrison Idaho.

15. Filed Jan 7 1915 R. B. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1914, to Dec 30 1914
that I last saw him alive on Dec 30 1914
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia.

..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Fenning M. D.
Dec 31 1914 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison
DATE OF BURIAL: Dec 31 1914

20. UNDERTAKER: E. W. Wheeler
ADDRESS: Harrison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

City of Burley

(No. ....., ... St.)

File No. .....

Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Schell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: Nov (Month) 22 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: Albert Schell

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Rosa Engkoff

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roger Snell
(Address) Burley Ida

15.
Filed Dec 9th 1914 Wm. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 8 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Gallagly, Coroner ~~M. D.~~

..... 19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Dec 9 191[illegible]

20. UNDERTAKER: L. A. Watt — ADDRESS: Burley Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196,

File No.

County of Cassia

City of Burley (No. , St.)

Registered No. 51.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Anderson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 27 (Day) 1878 (Year)

7. AGE: 31 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: C. F. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Anderson
(Address) Lund Idaho

15.
Filed Dec 28 1914 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Unknown 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Verdict of Jury was "cause of death Unknown"

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Goodwyn Coroner
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lund Idaho, — DATE OF BURIAL: Unknown 191...

20. UNDERTAKER: None — ADDRESS:

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 9838
Registered No. 52

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erick Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
February 8 (Month) (Day) 1875 (Year)

7. AGE
39 Yrs. 10 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER
Per Persson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER
Brita Martensdatter

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Olof Peterson
(Address) Burley

15.
Filed Dec. 21st 1914
Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 20th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7th 1914, to Dec. 20th 1914, that I last saw h... alive on Dec. 19th 1914 and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Inflammatory Rheumatism

.....(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
12-21 1914 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant View Cemetery — DATE OF BURIAL 12/23 1914

20. UNDERTAKER A. L. Pratt — ADDRESS Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

File No.

City of Burley

(No. ....., ... St.)

Registered No. 5-0

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Malburn Hamilton.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 17 (Day) 1888 (Year)

7. AGE: 26 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Washington Co, Utah.

10. NAME OF FATHER: Robert Hamilton

11. BIRTHPLACE OF FATHER (State or Country): Wasatch Co. Utah.

12. MAIDEN NAME OF MOTHER: Josephine Whitt

13. BIRTHPLACE OF MOTHER (State or Country): Tazewell Co. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Hamilton
(Address) Burley Idaho

15.
Filed Dec. 24th 191 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. (Month) 23rd (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1914., to Dec. 23d 1914, that I last saw him alive on Dec. 14th 1914, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) Paralysis mis brith

(Duration) 26 yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

12-23 1914 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Dec. 26th 1914

20. UNDERTAKER: L. B. Gallogly ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. .....
Registered No. 49
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Allen Landon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) Unknown (Day) 1848 (Year)

7. AGE: 66 yrs. 8 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): U.S.A.

10. NAME OF FATHER: Arby Landon

11. BIRTHPLACE OF FATHER (State or Country): U.S.A.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Gurdel
(Address) Burley Idaho.

15.
Filed Dec. 30th 1914 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Trouble.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. B. Gallogly. Coroner. M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery Burley Ida | DATE OF BURIAL: Dec 30th 1914

20. UNDERTAKER: L. B. Gallogly | ADDRESS: Burley Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

File No.

City of Burley

(No. ....., ... St.)

Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winfred Alden Rogers

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 25 (Day) 1907 (Year)

7. AGE: 7 yrs. 5 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... At Home
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Weber Co. Utah

10. NAME OF FATHER Theron L. Rogers

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake Co. Utah

12. MAIDEN NAME OF MOTHER Amelia Mortenson.

13. BIRTHPLACE OF MOTHER (State or Country) Weber Co. Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theron L. Rogers
(Address) RFD No2 Burley

15.
Filed Dec 18th 1914 Dag. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1914, to Dec 18 1914, that I last saw h-- alive on Dec 18 1914, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows: Typhoid Fever

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Minter M. D.

Dec 18 1914 (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Dec 19th 1914

20. UNDERTAKER: None ADDRESS: ---

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 154
Registered No. 46
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie Lamar Holt.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH: Sept. (Month) 2 (Day) 1913 (Year)

7. AGE: 1 yrs. 2 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alberta Canada

10. NAME OF FATHER: Jessie Richard Holt

11. BIRTHPLACE OF FATHER (State or Country): Wash. Co. Utah.

12. MAIDEN NAME OF MOTHER: Anna Marie Smith

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Holt
(Address) Burley Idaho

15. Filed Dec. 2nd 1914 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1914, to Dec 1 1914, that I last saw h[illegible] alive on May 31 1914 and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) J M Martin M. D.
Dec 3 1914 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. | DATE OF BURIAL: Dec 2 1914

20. UNDERTAKER: None. | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 1141
Registered No. 45

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Herbert King

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov. (Month) 9 (Day) 1914 (Year)

7. AGE
..... Yrs. ..... Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: Francis King

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER: Jennie Elizabeth [illegible]

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Francis King
(Address) .....

15.
Filed Dec. 6th 1914
Dr. J. C. Patterson
Local Registrar

SVIMS - YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9th 1914, to Dec. 5th 1914, that I last saw h[illegible] alive on Dec. 4th 1914, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Malnutrition
.....
.....
.....(Duration) ..... Yrs. ..... mos. 26 ds.

Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
12-6 1914 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetary — DATE OF BURIAL: 12/7 1914

20. UNDERTAKER: A. L. Hatt — ADDRESS: Burley

City of Bellevue (No. ....., ... St.) Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Lively Drager.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July 27th 1890. (Month) (Day) (Year)

7. AGE: 24 Yrs. 6 Mos. 3 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Chicago.

10. NAME OF FATHER: I. J. Lively

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. W. Drager

(Address) Bellevue Idaho

15. Filed Jan 1 1915 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 27th 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1914, to Dec 27th 1914, that I last saw her alive on Dec 27 1914 and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis with Heart Failure

13 hrs (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Collins M. D.

Dec 29 1914 (Address) Bellevue, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill. DATE OF BURIAL: Jan 1 1915

20. UNDERTAKER: R. D. Harris ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 1414
Registered No. 30

1. PLACE OF DEATH.
County of Blaine
City of Hailey
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oceania Marie Hazel Lilya

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 7 (Day) 1898 (Year)

7. AGE: 19 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓ ✓
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Christian Lilya

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Inge Paulson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clifford Lilya
(Address) Gannett Ida

15. Filed Jan 1 1915 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1914, to Dec 29 1914, that I last saw h[er] alive on Dec 29 1914, and that death occured on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal peritonitis following miscarriage at about 6 1/2 months. Acute Gonorrhea.
The miscarriage occured Dec 16th
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Adherent placenta
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C W Klemman M. D.
Dec 30 1914 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Silver Creek — DATE OF BURIAL: Dec 31 1914

20. UNDERTAKER: T F D Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24852

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

Primary Registration District No. [illegible]

File No. 114

County of Beaver

City of Hailey

(No. ....., ... St.)

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ole Rorem

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 24 (Day) 1850 (Year)

7. AGE: 64 Yrs. 5 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H H Johnson

(Address) .....

15. Filed Jan 1 1915

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1914, to Dec 26 1914, that I last saw him alive on Dec 26 1914, and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:

Mitro-Carditis

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Ales Pleurisy

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) R Rosenthal M. D.

Dec 1914 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey

DATE OF BURIAL: Dec 30 1914

20. UNDERTAKER: R W Harris

ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. ....., ... St.)

File No. .....
Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ora Joinette Ingram

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 26 (Day) 1914 (Year)

7. AGE: — yrs. 2 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Henry Manly Ingram

11. BIRTHPLACE OF FATHER (State or Country): Howell Co. Mo.

12. MAIDEN NAME OF MOTHER: Edith Clara Levander

13. BIRTHPLACE OF MOTHER (State or Country): Washington Co. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... Dec 8 1914
(Address) Weiser Idaho

15.
Filed 12/8 1914 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1914, to Dec 8 1914
that I last saw h[er] alive on Dec. 6 1914
and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Acute Endocarditis
Following Influenza

..... (Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E R Dunkley M. D.
..... 19..... (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser
DATE OF BURIAL: 12/9 1914

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No.
Registered No. 55

1. PLACE OF DEATH.,
County of Washington
City of Weiser (No. ..., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Golden Ellen Winchester

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 17 (Day) 1888 (Year)

7. AGE: 26 yrs. 2 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. M. Sheridan

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Laura M Coldwell

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Sheridan
(Address) Weiser

15. Filed 12/14 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 11 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 28 1914, to Dec 11 1914 that I last saw her alive on December 11 1914 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal septicemia.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.
Dec 14 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 12/14 1914

20. UNDERTAKER: L. C. Northam — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BAKER-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 2112
City of Weiser (No. ..., ..., St.)
File No. 1
Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reinaldo Trujillo

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 0 Yrs. 27 mos. ... ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 12/19 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 18 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suffocated: Caused by a cord of wood falling in the D.S.L. Waiting room at Eaton Station
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) RV Evidence of foul play
(Duration) ... yrs. ... mos. ... ds.
(Signed) James T. McCammon Coroner D.
12-18 1914 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Dec 23 1914

20. UNDERTAKER: L. L. Northam — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 952
Registered No. 57

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 212
City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Martin Castello

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE: About 45 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 12/19 1914 W. R. Wamsley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 15 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suffocation caused by a Cold & wood fire on the O.S.L. Hauling road at Eaton Station
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) No Evidence of foul play
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James T. McCann Coroner ~~M. D.~~
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....ds.
In the State .....yrs.....mos.....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida
DATE OF BURIAL: Dec 23 1914

20. UNDERTAKER: L. L. Northcutt
ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AVIS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. ..... St.)

File No. 953
Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas J. Brizendine

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: January (Month) 26 (Day) 1836 (Year)

7. AGE: 78 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas.

10. NAME OF FATHER: John A. Brizendine

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Edith Walker

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. R. Brizendine
(Address) Weiser Ida.

15. Filed 12/21 1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

found dead in a chair at home had been subject to ~~fainting~~ fainting spells

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) No indication of foul play

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James T McCam Coroner M. D.
Dec 21 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Dec 21 1914

20. UNDERTAKER: L. B. Northcraft — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. County of Washington City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. ....., ... St.)

File No. 45
Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Agnes Shannon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: October (Month) - 30 (Day) - 1841 (Year)

7. AGE: 73 yrs. 1 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Andrew Busbee

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ellen Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Shannon
(Address) Weiser Ida

15. Filed 12/21/1914 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) - 20 (Day) - 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20 1914, to Dec. 20 1914 that I last saw her alive on Dec. 20 1914 and that death occurred on the date stated above, at 12.20 P.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

..... (Duration) ..... yrs. 3 mos. ..... ds.
Contributory (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest O. Stinson M. D.
Dec 22 1914 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: Dec. 22 1914

20. UNDERTAKER: R. W. Bowen — ADDRESS: Weiser, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2174
File No. 9856
Registered No.

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Lane.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH: May (Month) 17 (Day) 1837 (Year)

7. AGE: 77 yrs. 7 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Attorney at
(b) General nature of industry business, or dstablishment in which employed (or employer): Law.

9. BIRTHPLACE (State or Country): Evansville Ind.

10. NAME OF FATHER: Joseph Lane

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Mary Hart

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Roy. C. Lane.
(Address): Lapwai Idaho.

15. Filed Dec. 26 1914 John N. Alley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1913, to Dec. 1914, that I last saw him alive on Dec. 24 1914 and that death occurred on the date stated above, at 12 oc M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 yrs. 6 mos. — ds.

Contributory (Secondary): Arteria-Sclerosis

(Duration) 15 yrs. — mos. — ds.

(Signed) Chas. A. Hatch M. D.

Dec. 26 1914 (Address) Lapwai Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho. DATE OF BURIAL: Dec. 26 1914

20. UNDERTAKER: J. A. Maus ADDRESS: Lapwai

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 97

Primary Registration District No. 2174

File No. 95

County of Nez Perce

City of Lapwai (No. Lapwai St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James L Bounds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Feb (Month) 12 (Day) 1830 (Year)

7. AGE: 84 yrs. 10 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Retired

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER James Bounds

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Nancy Loveday

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rachel Winterrowd
(Address) Lapwai, Idaho

15. Filed Dec. 28 1914 Nellie V. H. Habel Clerk, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1914, to Dec 27 1914, that I last saw him alive on 26 Dec 1914 and that death occurred on the date stated above, at 3a. M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 10 yrs. — mos. — ds.

Contributory (Secondary) Articular Arthritis

(Duration) — yrs. 4 mos. — ds.

(Signed) Nellie V. H. Habel M. D.

Dec 7 1914 (Address) Lapwai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Dec. 29 1914

20. UNDERTAKER: Vassar — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90 7/68

Primary Registration District No. 7/68

File No. 17

County of Clearwater

City of Orofino (No. ....., ... St.)

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachael Babcock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: 1839 (Month) (Day) 1 (Year)

7. AGE: 75 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence R Hill
(Address) Orofino, Ida

15. Filed Jany 1 1915 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 5th. (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26th. 1914, to Nov 5th 1914, that I last saw h. alive on Nov 5th 1914, and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Acute Mania

(Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary) Insanity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Evans M. D.

Nov 6 1914. (Address) Orofino. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos. 10 days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Sandpoint, Ida.

19. PLACE OF BURIAL ~~OR REMOVAL~~: Orofino, Ida. DATE OF BURIAL: Nov 7- 1914

20. UNDERTAKER: Clarence R. Hill ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 955
Registered No. 50

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmond Snyder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
1875 (Year) 1 (Day) ..... (Month)

7. AGE
39 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence R. Hill
(Address) Orofino, Ida

15.
Filed January 1 1915 J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov 27th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1907, to Nov. 27, 1914, that I last saw h[im] alive on Nov 26th 1914, and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Givens M. D.

Nov 27 1914. (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. 4 mos. 5 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Orofino, Ida. DATE OF BURIAL Nov 28 1914

20. UNDERTAKER Clarence R. Hill ADDRESS Orofino

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

File No. 986

County of Clearwater

City of Orofino (No. ....., ... St.)

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mike Welsch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

1839 (Month) 1 (Day) (Year)

7. AGE

75 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence R. Hill

(Address) Orofino, Ida

15.

Filed Jany 1, 1914 J. M. Tuttle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 30th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19th 1913, to Nov 30th 1914, that I last saw him alive on Nov 29th 1914, and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Stevens M. D.

Nov. 30 1914. (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 6 mos. 11 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Town Cemetery Orofino, Idaho | DATE OF BURIAL Dec. 3rd 1914

20. UNDERTAKER W. A. Shaw | ADDRESS Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

File No. 1514

Registered No. 53

County of Clearwater

City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thurman G. Fitz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 6 (Day) 1864 (Year)

7. AGE: 52 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labor
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Andrew G Fitz

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: S. Stinson

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Fitz
(Address) Genesee Ida

15. Filed: Jany 16 1914 J. M. Fairley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1914, to Dec 16 1914, that I last saw h[illegible] alive on Dec 16 1914 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Fairley M. D.

Dec 17 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: Dec 17 1914

20. UNDERTAKER: W. L. Stoddard — ADDRESS: Gifford Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 42

Primary Registration District No. 2108

File No. 1414

County of Clearwater

City of Ahsahka (No. ....., ... St.)

Registered No. 5-2

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.)
Male	Indian	Married

6. DATE OF BIRTH: Apr (Month) 16 (Day) 1912 (Year)

7. AGE: 1 yrs. 7 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: William Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Julia Scott.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earle W Horswell
(Address) Orofino Ida

15.
Filed Dec 18 1914 J M Fairley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1914 to Dec 7 1914, that I last saw him alive on Dec 7 1914 and that death occurred on the date stated above, at 5.05 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia-followed by an acute gastro-enteritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle W Horswell M. D.
Dec 9 1914 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ahsahka — DATE OF BURIAL: Dec 8 1914

20. UNDERTAKER: W C Stoddard — ADDRESS: Gifford Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. , St.)
File No.
Registered No. 64
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry William Allen, Alias, William Henry Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Not known

6. DATE OF BIRTH
1871 (Year) (Month) 1 (Day)

7. AGE
43 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence R. Hill
(Address) Orofino, Idaho

15.
Filed Jany 11 1915 J. McJaing Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. (Month) 19. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12. 1910., to Dec. 19. 1914, that I last saw h im alive on Dec. 19. 1914, and that death occurred on the date stated above, at 6.30 P. M.

The CAUSE OF DEATH* was as follows:
Epilepsy

(Duration) 4 yrs. 2 mos. 7 ds.
Contributory (Secondary) Insanity
(Duration) 4 yrs. 2 mos. 7 ds.
(Signed) John M. Sivans M. D.
Dec 19 1914 (Address) Orofino - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State 4 yrs. 2 mos. 7 days.
Where was disease contracted if not at place of death? ?
Former or usual residence Kootenai

19. PLACE OF BURIAL OR REMOVAL: The N. J. Sanitarium Cemetery. DATE OF BURIAL: Dec 22. 1914

20. UNDERTAKER: O. ADDRESS: ✓

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

Primary Registration District No. 2177

File No.

County of Fremont

City of Dohna (No. ..... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Murphey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.

June (Month) 16 (Day) 1879 (Year)

7. AGE: 35 Yrs. 6 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Chicago Ill.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. V. Stanger

(Address) Ashton Idaho

15. Filed Jan 9th 1915

Local Registrar

SYRACUSE, N.Y. CO., PTRS. & BOOK. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1914, to Dec 16 1914, that I last saw her alive on Dec 16 1914, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Gall Stones

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Infection Pneumonia

(Duration ..... yrs. ..... mos. 7 ds.

(Signed) E. V. Stanger M. D.

1914 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill.

DATE OF BURIAL 191

20. UNDERTAKER: F. A. Rogers

ADDRESS St Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2155

File No. .....
Registered No. 674
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thomas Daly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Lumberjack
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Do

11. BIRTHPLACE OF FATHER (State or Country): Do

12. MAIDEN NAME OF MOTHER: Do

13. BIRTHPLACE OF MOTHER (State or Country): Do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Brown
(Address) Sandpoint Idaho

15.
Filed Feb 8 1915 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 30 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1914, to Dec 30 1914
that I last saw him alive on Dec 30 1914,
and that death occurred on the date stated above, at 7 15 P M.
The CAUSE OF DEATH* was as follows:
Cirrosis of the liver.

(Duration) ? yrs. ..... mos. ..... ds.
Contributory (Secondary) Alcoholism
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E T Payne M. D.
19 ..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: Jan 3 1915

20. UNDERTAKER: E M Brown & Co.
ADDRESS: Sp.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Gilmore
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 42
Primary Registration District No. 2133
(No. ....., ... St.)

File No. 9877
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Whittaker Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
June 23rd 1870
(Month) (Day) (Year)

7. AGE
24 yrs. 5 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner and Time Keeper
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Montana

10. NAME OF FATHER
Peter Miller

11. BIRTHPLACE OF FATHER
(State or Country) Canada

12. MAIDEN NAME OF MOTHER
Miss Whitaker

13. BIRTHPLACE OF MOTHER
(State or Country) Michigan or Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C. M. Perkins
(Address) Gilmore Idaho

15.
Filed Dec 4 1914 Emma S Story
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
December 2nd 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
(Accidental) Asphyxia
Caused by powder Burns
in mine
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Doebler Coroner
12-2nd 1914 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Great Falls Montana | DATE OF BURIAL ..... 191...

20. UNDERTAKER: W. C. Doebler | ADDRESS: Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Gilmore
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 42
Primary Registration District No. 2153
(No. ....., ... St.)

File No. 9878
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Marie Merith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Do not know (Month) (Day) 1 (Year)

7. AGE: about 40 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cooking for Mining Camp
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Do not know

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Dockler Coroner
(Address) Salmon Idaho

15.
Filed Nov 13 1914 John W. Story Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 12" 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:
Natural Causes due to Asthma.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) High Altitude
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Dockler Coroner M. D.
11-13" 1914 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Gilmore Idaho
DATE OF BURIAL: 11-16" 1914

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 401
County of Twin Falls Primary Registration District No.
City of Hollister (No. , St.)
File No. 1
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ray F. Harp Standley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct. 17 1911 (Month) (Day) (Year)

7. AGE: ..yrs. ..mos. 7 ds. IF LESS than 1 day how many ....hrs. or ....min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: X
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hollister Idaho.

10. NAME OF FATHER: Saml Standley

11. BIRTHPLACE OF FATHER (State or Country): Arkansas,

12. MAIDEN NAME OF MOTHER: Edna Haghurst

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Saml Standley
(Address): Hollister, Idaho,

15. Filed ....191.... W. A. Parrett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 21 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17 1914, to Oct. 21 1914, that I last saw him alive on Oct. 18 1914, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows: Tuberculosis

(Duration) ..yrs. ..mos. 7 ds.

Contributory (Secondary): X

(Duration) ..yrs. ..mos. ..ds.

(Signed) W. A. Parrett M. D.
Oct. 24 1914 (Address) Hollister, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs ..mos ..ds. In the State ..yrs ..mos ..ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Rock Creek, Idaho — DATE OF BURIAL: Oct. 22 1914

20. UNDERTAKER: Saml Standley — ADDRESS: Hollister Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 40
County of Twin Falls, Primary Registration District No.
City of Hollister (No. , St.)
File No.
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edna Standlee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the Word): Married
6. DATE OF BIRTH: Dec. 23 1914 (Month) (Day) (Year)
7. AGE: 29 yrs. 7 mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Arkansas.
10. NAME OF FATHER: W. A. Hastings
11. BIRTHPLACE OF FATHER (State or Country): Arkansas.
12. MAIDEN NAME OF MOTHER: Margaret Hurd
13. BIRTHPLACE OF MOTHER (State or Country): Arkansas.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Paul Standlee
(Address): Hollister Idaho
15.
Filed 191 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 23 1914 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1914, to Dec. 23 1914, that I last saw her alive on Dec. 2 1914, and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) yrs. 2 mos. 6 ds.
Contributory (Secondary) X
(Duration) yrs. mos. ds.
(Signed) W. A. Garrett M. D.
Dec. 24 1914 (Address) Hollister Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Rock Creek | DATE OF BURIAL: Dec. 24 1914
20. UNDERTAKER: Paul Standlee | ADDRESS: Hollister Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville

City of R D 1 Ida Falls (Lincoln)

Registration District No. 73

Primary Registration District No. 21d 2

(No. ..... St.)

File No. 1911

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leland T. McMullen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 23 (Day) 1902 (Year)

7. AGE: 12 Yrs. 6 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Eli G. McMullin

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Phoebe Angel

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. P. McMullen

(Address) Ida Falls

15. Filed Jan 7 1915

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1914, to Dec. 8, 1914, that I last saw him alive on Dec. 8, 1914, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) Indefinite Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pulmonary Edema

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. O. Mellen M. D.

1/7 1915 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Lincoln Ida — DATE OF BURIAL: Jan. 1915

20. UNDERTAKER: C. C. Dinwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 86

Primary Registration District No. 1010.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1111.

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

County of Washington

City of Weiser

(No. W. Commercial St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Henry Forbes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married. (Write the word.)

6. DATE OF BIRTH. March 26th 1837 (Month) (Day) (Year)

7. AGE 77 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Planter.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER John Forbes.

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Ellen Johnston.

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nancy E. Forbes

(Address) Weiser Ida.

15. Filed Sept. 17th 1914 W. P. Chamberlin Local Registrar

BYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 15th 1914. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1914, to Sept 15 1914, that I last saw him alive on Sept 15 1914, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

..... (Duration ..... yrs. ..... mos. ..... ds.

Sept 17 1914 (Signed) James A. Young M. D.

(Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Weiser Idaho | **DATE OF BURIAL** Sept 19 1914

20. UNDERTAKER R. F. Bowen | **ADDRESS** Weiser, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
(No. ....., ... St.)

File No. .....
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Jackson
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James M Hopkins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH.
May (Month) 4 (Day) 1870 (Year)

7. AGE
44 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Georgia

10. NAME OF FATHER Jacob Hopkins

11. BIRTHPLACE OF FATHER (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Jennie Hastes

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. B. Hopkins
(Address) Jackson Idaho

15.
Filed 1/19 1915
O. H. Scott
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1914, to Nov 19 1914, that I last saw him alive on Nov 18 1914, and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Scott M. D.
..... 19..... (Address) Rupert.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Nov 20 1914

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 444

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....

Primary Registration District No. .....

(No. ..... St.)

1. PLACE OF DEATH.

County of Cassia

City of Jackson

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen Valleu

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug 5 1880 (Month) (Day) (Year)

7. AGE 34 Yrs. 5 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER A. J. Valleu

11. BIRTHPLACE OF FATHER (~~State or~~ Country) Norwa

12. MAIDEN NAME OF MOTHER Malinda Stephenson

13. BIRTHPLACE OF MOTHER (State or Country) Norwa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) O. J. Valleu

15. Filed 1/19 1915 O. H. Scott Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 27 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1914, to Dec 27 1914, that I last saw ~~him~~ alive on Dec 21 1914, and that death occured on the date stated above, at 2 P. M.

The ~~CAUSE~~ OF DEATH* was as follows:

Typhoid Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. P. Lemon M. D.

19..... (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery

DATE OF BURIAL Dec 29 1914

20. UNDERTAKER W. A. Gardeman

ADDRESS Rupert

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9955
Registered No. .....

1. PLACE OF DEATH.
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susan Ravenscroft

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 27 (Day) 1840 (Year)

7. AGE 74 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER John Bolton

11. BIRTHPLACE OF FATHER (State or Country) Ken

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER " "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nate [illegible]
(Address) .....

15. Filed 1/9 1915 O. Scott Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 19 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th 1914, to Dec. 16th 1914, that I last saw h[illegible] alive on Dec 16 1914, and that death occured on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) 2 weeks Yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration ..... yrs. ..... mos ..... ds.
(Signed) W. F. Rowley M. D.
19..... (Address) Rupert, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Dec 21 1914

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Minidoka — Registration District No. .....

City of Heyburn — Primary Registration District No. .....

(No. ....., ... St.)

File No. 115

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George L Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. June (Month) 19 (Day) 1909 (Year)

7. AGE: 5 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Walter L Cole

11. BIRTHPLACE OF FATHER (State or Country): N York

12. MAIDEN NAME OF MOTHER: Blanch E Lovell

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) letter from W. L. Cole

(Address) Heyburn Idaho

15. Filed 1/19 191 5 — O. H. Scott, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed).....M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Dec 27 1914

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9957
Registered No. .....

1. PLACE OF DEATH.
County of Minidoka
City of Rupert
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dudley A Barton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dont Know (Month) (Day) 1 (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Wilbastin Barton

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Barton
(Address) .....

15. Filed Jan 19 1915 — O. A. Scott, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1914, to Dec 25 1914, that I last saw him alive on Dec 25 1914, and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Bladder
(Duration) One Yrs. ? mos. ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J B K ..... M. D.
19..... (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Dec 1914

20. UNDERTAKER: W. O. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & BDGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9958

Registered No. .....

1. PLACE OF DEATH.
County of Minidoka
City of Rupert
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Alan Hardy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH. July (Month) 31 (Day) 1910 (Year)

7. AGE 4 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER W. W. Hardy

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Holmes

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm. Hardy
(Address) Rupert, Idaho

15. Filed JAN 19 1915 O. H. Scott Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 16 (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1914, to Dec 26 1914, that I last saw h alive on Dec 26 1914, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Diphtheria
.....
.....
(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Kennedy M. D.
19..... (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery — DATE OF BURIAL .....191.....

20. UNDERTAKER W. G. Goodmen — ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

County of Bannock — Primary Registration District No. [illegible] — File No. 9959

City of Grace (No. ....., ... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond R. Cole

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated in PLAIN terms, so that it may be properly copied. CAUSE OF DEATH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 6 (Day) - 1887 (Year)

7. AGE: 27 yrs. 1 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Clarks, Nebraska

10. NAME OF FATHER: Saml Cole

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Delilah Richmond

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Aug 20, 1914 — John H Hubbard — Local Registrar

[illegible] 17142

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1914, to Aug 20, 1914 that I last saw him alive on Aug 20 1914 and that death occurred on the date stated above, at 15 P. M.

The CAUSE OF DEATH* was as follows:
Hemorrhagic Purpura

..... (Duration) ..... yrs. ..... mos. 14 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Hubbard M. D.
Aug 20 1914 (Address) Grace Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Do not know
Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL: Nyssa Oregon — DATE OF BURIAL: ..... 191..

20. UNDERTAKER: Roy Russell — ADDRESS: [illegible] Pocatello Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. 0121 8th St.)

File No. 112
Registered No. 4

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H J Fisher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Oct (Month) 2 (Day) 1 78 (Year)

7. AGE: 78 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Carl Fisher

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dorothea Kuhn

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H Wampner
(Address) Culdesac Idaho

15. Filed Feb. 10 1915 L J Perkins Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/8 1914, to 12/12 1914, that I last saw him alive on 12/12 1914, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Old age and Valvular Heart disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) L F Putnam M. D.
19..... (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos 10 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Culdesac Ida.

19. PLACE OF BURIAL OR REMOVAL: Culdesac — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5711

Registered No. .....

1. PLACE OF DEATH.

County of Kootenai

City of Desmet, Idaho

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Ignace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 7 (Day) 1914 (Year)

7. AGE ..... Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Reservation, Ida

10. NAME OF FATHER: John Ignace

11. BIRTHPLACE OF FATHER (State or Country): Reservation, Ida

12. MAIDEN NAME OF MOTHER: Lizzie Vincent

13. BIRTHPLACE OF MOTHER (State or Country): Reservation Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Ignace,

(Address) Desmet, Ida

15.

Filed Nov. 13th 1914

Geo. J. Kuepler
Local Registrar
Per John Post

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

No medical attendance.
Supposed to be from
a cold.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Ballard M. D.

11/13 1914. (Address) Desmet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Desmet, Idaho — DATE OF BURIAL: Nov. 13, 1914

20. UNDERTAKER: None — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of DeSmet Ida.

Registration District No. 31

Primary Registration District No.

(No. ..... St.)

File No. 111

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Basil Dennis Isidore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. June (Month) 23rd (Day) 1910 (Year)

7. AGE: 4 Yrs. 6 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) DeSmet, Idaho

10. NAME OF FATHER: Dennis Isidore

11. BIRTHPLACE OF FATHER (State or Country) DeSmet, Idaho

12. MAIDEN NAME OF MOTHER: Sabine Francois

13. BIRTHPLACE OF MOTHER (State or Country) DeSmet, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dennis Isidore

(Address) DeSmet, Idaho

15. Filed Dec. 18th 1914

Geo. J. Kugler per J. Post Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Nat Tenanus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Leeland M. D.

12/18 1914 (Address) DeSmet Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: DeSmet Ida — DATE OF BURIAL: Dec. 19 1914

20. UNDERTAKER: Petting — ADDRESS: John Post DeSmet Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 31

File No. 11

County of Kootenai

Primary Registration District No.

Registered No.

City of De Smet, Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Dennis Isidore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Oct. (Month) 7 (Day) 1913 (Year)

7. AGE: ..... Yrs. 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) DeSmet, Idaho

10. NAME OF FATHER: Dennis Isidore

11. BIRTHPLACE OF FATHER (State or Country) DeSmet, Idaho

12. MAIDEN NAME OF MOTHER: Sabine Frank

13. BIRTHPLACE OF MOTHER (State or Country) DeSmet, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dennis Isidore

(Address) DeSmet, Idaho

15. Filed Dec. 24 1914 Geo. J. Ziegler per J. Post Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw her alive on Dec 23 1914, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Yrs. 2 mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Ballard M. D.

12/24 1914 (Address) Desmet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: DeSmet Ida — DATE OF BURIAL: Dec 24 1914

20. UNDERTAKER Acting — John Post — ADDRESS DeSmet Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

Pd. 25 cents

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 8
County of Ada Primary Registration District No. 2004
~~City of~~ (No. New Eagle St.)
File No. 1015
Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Helen Vincent

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Nov. (Month) 18 (Day) 1914 (Year)
7. AGE: ..... yrs. ..... mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Boise
10. NAME OF FATHER: Chas Vincent
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Sadie Richardson
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Vincent
(Address) Near the Boise
15.
Filed 12-15 1914 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 14 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 191..., to Dec 14 1914
that I last saw her alive on Dec 12 1914,
and that death occurred on the date stated above, at 7 P— M.
The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L LeBarron M. D.
Dec 15 1914 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the Boise valley State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? No disease
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: Dec 16 1914
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Lanark
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53
Primary Registration District No. 2132
(No. ....., ... St.)

File No. 10063
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milford Passey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W.	~~Single~~

6. DATE OF BIRTH: Dec 16 1905
(Month) Dec, (Day) 13, (Year) 1914

7. AGE: 9 yrs. 8 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Boy (School)
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Paris Idaho

10. NAME OF FATHER Fredrick Passey

11. BIRTHPLACE OF FATHER (State or Country) Paris

12. MAIDEN NAME OF MOTHER Julia Beck

13. BIRTHPLACE OF MOTHER (State or Country) Paris Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. F. Parke
(Address) Lanark Ida

15. Filed 4-1 1914 C. P. Fulton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8. 1914, to Dec 13 1914, that I last saw h~~is~~ alive on Dec 12 1914 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Labyngitis (Croup)

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) C. D. Eyden M. D.
Dec 13 1914 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lanark	Dec 15 1914
20. UNDERTAKER	ADDRESS
None	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 10760

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 14
County of Custer
City of Challis (No. ....., ... St.)
Primary Registration District No. .....
File No. 10085
Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. C. Dougherty

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1850 (Year)

7. AGE: 64 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner—Late Saloon Keeper
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Philadelphia

10. NAME OF FATHER: Neil Dougherty

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Hannah Gallagher

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. A. Dougherty
(Address) Edwardsburg Idaho

15. Filed 9/16 1914 C. E. Bartley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 12 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1914, to Sept 14 1914
that I last saw him alive on Sept 13 1914
and that death occurred on the date stated above, at 6.20 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) 7 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Bartley M. D.
9/16 1914. (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Challis — DATE OF BURIAL: Sept 16 1914

20. UNDERTAKER: E. Roberts Jr. — ADDRESS: Challis

N. B.—Every item of information should be stated EXACTLY AS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1111
Registered No. 74

1. PLACE OF DEATH.
County of Custer
City of Challis
Registration District No.
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Will Treloar.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Dec 14th 1899
(Month) (Day) (Year)

7. AGE 21 yrs. 10 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Ranch hand
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W. J. Treloar

11. BIRTHPLACE OF FATHER (State or Country) Charleston South Carolina

12. MAIDEN NAME OF MOTHER Alice Kune

13. BIRTHPLACE OF MOTHER (State or Country) Corinne Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. D. Williams
(Address) Challis Idaho

15.
Filed Oct 6th 1914 C. L. Kistler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 5 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1914, to Oct 5 1914, that I last saw h~~im~~ alive on Oct 5 1914, and that death occurred on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:
Rupture of blood vessel in base of lung.

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Kelley M. D.
Oct 5 1914. (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Challis
DATE OF BURIAL Oct 6 1914

20. UNDERTAKER E. D. Williams
ADDRESS Challis Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4 71

Primary Registration District No. 20 H 2148

File No. 10128

County of Adams

City of Indian Valley (No. ....., ... St.)

Registered No. 65

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Burch

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug. (Month) 22 (Day) 1853 (Year)

7. AGE: 61 yrs. 3 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John Budgeley.

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Badgeley

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jane Burch
(Address) Indian Valley, Idaho

15.
Filed 1-26-15 191 Frank E Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
11 (Month) — 25 (Day) — 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 — 1914, to ..... 191..., that I last saw her alive on Nov 10 1914 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank E Brown M. D.

1-26 1915 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: 11-26 1914

20. UNDERTAKER: Ross Young — ADDRESS: Council

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10142

Registered No. 3731

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 609 South 15 St St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha G Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 2 (Day) 1839 (Year)

7. AGE: 75 Yrs. 10 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Alexander Wilson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Swaitz

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D O Eytchison
(Address) 609 S 15 St

15. Filed 1-2 1915 M S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20th 1914, to Dec 30th 1914, that I last saw h alive on Dec 30th 1914 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis -

(Duration) Many Yrs. — mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19 .... (Address) John Baer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill | DATE OF BURIAL: Jan 2 1915

20. UNDERTAKER: Frye & Summers | ADDRESS: Boise Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 10143
Registered No. 3742

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 918, Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James L Brooks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1855 (Year)

7. AGE: 59 yrs. mos. 2 ds. 19 | IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Co. Mo.

10. NAME OF FATHER: John Brooks

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James Brooks
(Address) Boise

15.
Filed 1-2 1915 M S Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 30th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27th 1914, to Dec 30th 1914 that I last saw h[illegible] alive on Dec 30 1914 and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from mouth after extraction of teeth

8½ hours (Duration) — yrs. — mos. — ds.

Contributory (Secondary) Senile senescence

(Duration) yrs. mos. ds.

(Signed) L. M. Taylor M. D.
Dec 31st 1914 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan. 2 1915

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10144

Registered No. 3753

1. PLACE OF DEATH.

County of Ada.

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glenn G. Monroe.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sep 29 (Month) (Day) 1908 (Year)

7. AGE: 6 Yrs. 3 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Harvey A. Monroe.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Maud Trent

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harvey A. Monroe

(Address) Boise

15. Filed Jan 2 1915 W S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 31 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15th 1914, to Dec 31st 1914, that I last saw him alive on Dec 31st 1914 and that death occured on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia following measles reported as last seen by physician at that time —

(Duration) ..... Yrs. — mos. ..... ds.

Contributory (Secondary) presumable typhoid.

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) H. Burnett M. D.

19 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Boise Ida

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan 4 1915

20. UNDERTAKER: Trey & Summers — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 110, East Bannock St.)

Registration District No. 2
Primary Registration District No. 1004

File No. 10145
Registered No. 3764

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hang Dee Foun

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ——— (Month) ——— (Day) 1845 (Year)

7. AGE: 69 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gardner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant):
(Address):

15. Filed Jan 2 1915 — Mrs Parker — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 31 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1914, to Dec 31, 1914 that I last saw h[e] alive on Dec 31 1914 and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:
Hypostatic pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jas Barrick M. D.
Jan 2nd 1915 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery — DATE OF BURIAL: Jan 2 1915

20. UNDERTAKER: Schreiber & Sidmore — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No.
Primary Registration District No.
(No. 110, East Bannock St.)

File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Fong Sue Yuen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 69 yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gardner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Not attainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fong Sue Yuen
(Address) Boise City

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
(Month) (Day) 191... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191... that I last saw h... alive on ..... 191... and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery
DATE OF BURIAL: Jan 2 1914

20. UNDERTAKER: Schreiber & Hillenbrand
ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10147

Registered No. 7

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1506 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margret G Brumley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April 25 (Month) (Day) 1833 (Year)

7. AGE: 81 Yrs. 8 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: William Patterson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Shanks

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E B Whitney

(Address) 1506 State St

15. Filed Jan 4 1915

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 2 (Day) 1915 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/16 1914, to 1/2 1915, that I last saw her alive on 1/2 1915, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Senility

(Duration yrs. mos. ds.

(Signed) Fred A Fetherolf M. D.

1/4 1915 (Address) Jack Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill

DATE OF BURIAL: Jan 4 1915

20. UNDERTAKER: Gray & Summers

ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 10151
Registered No. 13

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1307 No. 11 — St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter M. Thomsen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 27 (Day) 1910 (Year)

7. AGE: 4 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Ludwig Thomsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Lottie A Johnson.

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ludwig Thomsen
(Address) 1307 North 11th, Boise, Ida.

15. Filed Jan 5 1915 — M S Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5th 1914, to Dec. 28 1914, that I last saw h[illegible] alive on Dec. 28 1914, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Sarcoma of Kidney
(Duration) Yrs. 6 mos. — ds.
Contributory (Secondary) —
(Duration ... yrs. ... mos. ... ds.

(Signed) Jos R Nunnagor M. D.
Dec 31 1914 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ann Arbor Mich — DATE OF BURIAL: ... 191...

20. UNDERTAKER: Fry & Summers. — ADDRESS: Boise Ida.

BYNS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65.
Primary Registration District No. 2145.
File No. 10176
Registered No. .....

1. PLACE OF DEATH.
County of Latah.
City of Potlatch
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lolla Raponi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single.

6. DATE OF BIRTH. Sept. (Month) 7 (Day) 1914. (Year)

7. AGE: .....Yrs. 18 Mos. ..... ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Tony. Raponi.

11. BIRTHPLACE OF FATHER (State or Country): Italy.

12. MAIDEN NAME OF MOTHER: Aranda. Notta

13. BIRTHPLACE OF MOTHER (State or Country): Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Andy Raponi.
(Address) Potlatch

15. Filed Feb. 6th 1915. J. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191...,
that I last saw h ✓ alive on ✓ 191...,
and that death occured on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH* was as follows:
Accidental Strangulation

.....(Duration) ✓ Yrs. ✓ mos. ..... ds.
Contributory (Secondary) ✓
.....(Duration ✓ yrs. ..... mos. ..... ds.
(Signed) J. Jr. Thompson M. D.
Feb 6 1915 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch. DATE OF BURIAL: Feb. 7 1915.

20. UNDERTAKER: Parents. ADDRESS: Potlatch.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 10184
Registered No. 246

1. PLACE OF DEATH.
County of Kootenia
City of Post-Falls.

Registration District No. 1½
Primary Registration District No. 2051
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Shields

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Sept. (Month) 25 (Day) 1914 (Year)
7. AGE: — yrs. 3 mos. —ds.
IF LESS than 1 day how many .....hrs. or .....min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Post-Falls - Idaho
10. NAME OF FATHER: Frank Shields
11. BIRTHPLACE OF FATHER (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Anna Carter
13. BIRTHPLACE OF MOTHER (State or Country): Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.F. Caulbell M.D.
(Address) Post Falls, Ida.
15. Filed 2/10 1915 J.D. Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 23 (Day) 1915 (Year)
17. I HEREBY CERTIFY, That I attended deceased from December 19 1915, to December 24 1915 that I last saw h[illegible] alive on December 23 1915 and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia (Broncho-Pneumonia
(Duration) — yrs. — mos. 5 ds.
Contributory (Secondary) Cerebro-Spinal complications
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) B.F. Caulbell M. D.
Jan. 7 1915 (Address) Post-Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 4 mos. 15 ds. In the State ..... yrs. 4 mos. 15 ds.
Where was disease contracted, [illegible]
If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Post-Falls. DATE OF BURIAL: Dec 26 1914
20. UNDERTAKER: Cassidy & Nelson ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Power
City of Am Falls

Registration District No. 20
Primary Registration District No. 2072
(No. ....., ... St.)

File No. 10200
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johan Emil Martens

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~

6. DATE OF BIRTH: July (Month) 26 (Day) 1884 (Year)

7. AGE: 30 yrs. 5 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Gustave Martens

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Catherine Mercker

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gustav Martens
(Address) Colfax Ida

15. Filed Dec 30 1914 — R F. Mott M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1914, to Dec 28 1914, that I last saw him alive on Dec 28 1914 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Concussion of brain caused by kick from horse

..... (Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R F Mott M. D.
12/28 1914 (Address) Am Meriean Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Valley
DATE OF BURIAL: 12/31 1914

20. UNDERTAKER: A R Hayes
ADDRESS: Am Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1020 1

Registered No.

1. PLACE OF DEATH.
County of Power
City of American Falls, (No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena Deeg.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 7 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Deeg Jr

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Paulina Burgmeister

13. BIRTHPLACE OF MOTHER (State or Country): Roumania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Deeg Jr
(Address) American Falls Ida Route

15. Filed Jan 30 1914 R. E. Noth, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Did not know - died before medical aid could be called.

..... (Duration) ..... yrs. ..... mos. — ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: at Home —
DATE OF BURIAL: Dec 11 1914

20. UNDERTAKER: Mons
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Kellogg

Registration District No. 4-2-3

Primary Registration District No. 2201

(No. ....., ... St.)

File No. 7

Registered No. 10219

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Johnson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec (Month) 25 (Day) 1914 (Year)

7. AGE ....Yrs. ....Mos. ....ds. IF LESS than 1 day how many ....hrs. or 1 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kellogg, Idaho.

10. NAME OF FATHER Nels Johnson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Elmire Velander

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nels Johnson
(Address) Kellogg Idaho

15. Filed 2/12 1915 Geo I Leahy Local Registrar

SYMS - YORK CO., PTGS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....,
that I last saw h....alive on ....191....,
and that death occured on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Still Born.

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) .....

....(Duration ....yrs. ....mos. ....ds.

Dec 28 1914 (Signed) J. R. Wilson M. D.
(Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho. DATE OF BURIAL: Dec 26 1914

20. UNDERTAKER: M C Trombley ADDRESS: [illegible], Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 1024
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of Plummer (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kyse Hallstrand

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1845 (Year)

7. AGE: 69 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charley Hallstrand
(Address) Plummer, Idaho

15. Filed Dec 20 1915
K L Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Evergreen Cemetery — DATE OF BURIAL: 12/22 1914

20. UNDERTAKER: L. L. Jaeger — ADDRESS: Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYUS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1025

Registered No.

1. PLACE OF DEATH.

County of Shoshone

City of Clarkia

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernie Bernice Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Girl	White	Single

6. DATE OF BIRTH

June (Month) 25 (Day) 1912 (Year)

7. AGE

2 yrs. 6 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Hatton Washington

10. NAME OF FATHER W. A. Williams

11. BIRTHPLACE OF FATHER (State or Country) Trading Post, Kans.

12. MAIDEN NAME OF MOTHER Mary E. Spencer

13. BIRTHPLACE OF MOTHER (State or Country) Bussell, Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Williams

(Address) Clarkia, Idaho.

15.

Filed Jan. 4 1915 H. L. Mulkey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December (Month) 30th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1914 to Dec 30 1914 that I last saw her alive on Dec 29 1914 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — yrs. — mos. 6 ds.

Contributory (Secondary) Cold

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Kinnebrew M. D.

Jan 6 1915 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Clarkia Idaho

DATE OF BURIAL .....191...

20. UNDERTAKER H. L. Mulkey

ADDRESS St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176

File No. 11025
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME No name.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	Babe

6. DATE OF BIRTH: Dec (Month) 24th (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?* 4

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Clements Jr.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Grace Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Eli McIntyre
(Address): Rexburg, Ida

15. Filed Dec 10 1914 Boyd Fisher Local Registrar
Jeff

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 4 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1914, to Dec 4 1914, that I last saw him alive on Dec 4 1914, and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

Atelectasis.
Congenital heart weakness

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewisville	Dec 4 1914

20. UNDERTAKER	ADDRESS
M. T. Peck	Rigby Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. 1-7RS. 1-5DRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

County of Jefferson

Primary Registration District No. 2176

File No. 1915

City of Annis

(No. ....., ... St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No name given

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Dec. 25 1914 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Annis, Ida

10. NAME OF FATHER: Harry Strand

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Miss. Pierce

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Harry Strand
(Address): Lowman, Idaho

15. Filed Feb 10 1915 Ray Whitaker Local Registrar RDI

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. 28 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 25 1914, to Dec. 28 1914, that I last saw her alive on Dec. 28 1914 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer, M. D.

Dec. 29 1914 (Address) Reg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Annis Cemetery — DATE OF BURIAL: Dec. 30 1914

20. UNDERTAKER: Friends — ADDRESS: Annis

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Roberts. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176

File No. 10251
Registered No. 3.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosina A. Wells.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH: April (Month) 20 (Day) 1869 (Year)

7. AGE: 45 yrs. 6 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: Lester Wells.

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: — Welch

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. R.A. Wells.
(Address) Roberts, Idaho.

15. Filed Jan 10 1915 Ray St. Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 6 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 1:30 a. M.

The CAUSE OF DEATH* was as follows:

No attendant. Sudden death.
Probably Angina Pectoris
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Probably Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray St. Fisher M. D.
Nov 10 1914 (Address) Ryley - Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: N.Y. | DATE OF BURIAL: Dec 8 1914

20. UNDERTAKER: T.H. Hunt. | ADDRESS: Idaho Falls, Idaho.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Darlington (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 239

File No. 21
Registered No. 1021
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Homer Grant Phillips.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: American
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: December 11. 1914.
(Month) (Day) (Year)

7. AGE: ....yrs. ....mos. ....ds.
IF LESS than 1 day how many 3.5 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ——
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Grant Phillips.

11. BIRTHPLACE OF FATHER (State or Country): Arkansas.

12. MAIDEN NAME OF MOTHER: Hazel Belle McCullough

13. BIRTHPLACE OF MOTHER (State or Country): Antelope.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grant Phillips.
(Address) Darlington Idaho.

15.
Filed Dec 15 1914 Ens ....., Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December 12 1914.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...
that I last saw h..... alive on ....., 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No medical attendance

..... (Duration) ....yrs. ....mos. ....ds.
Contributory .....
(Secondary)
..... (Duration) ....yrs. ....mos. ....ds.
(Signed) ..... M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Antelope.
DATE OF BURIAL: Dec 14 1914

20. UNDERTAKER: G. Phillips
ADDRESS: Darlington, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1035

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 79.

Primary Registration District No. 5156.

County of Bonner

City of Moravia (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis Jordan Simmons.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: December 17 (Month) (Day) 1846 (Year)

7. AGE: 67 yrs. 11 mos. 20 ds. IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois U. S. A.

10. NAME OF FATHER: M. Simmons

11. BIRTHPLACE OF FATHER (State or Country): New York U. S. A.

12. MAIDEN NAME OF MOTHER: Jordan

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. A. Hatchett
(Address) Moravia Ida.

15. Filed Dec. 7- 1914. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 6th. (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12, -1914, to Dec. 6 -1914, that I last saw h.. alive on Dec. 5- 1914 and that death occurred on the date stated above, at ..M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) E E Fry M. D.

12/7 1914 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moravia Ida | DATE OF BURIAL: Dec 9 1914

20. UNDERTAKER: B. J. Thomas | ADDRESS: Moravia, Ida

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 3156.
File No. 103
Registered No.

1. PLACE OF DEATH.
County of Bonner
City of Bonners Ferry (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John D. Fallon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
63 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Huntington County Quebec

10. NAME OF FATHER Michael Fallon

11. BIRTHPLACE OF FATHER (State or Country) Roscommon Ireland

12. MAIDEN NAME OF MOTHER Margaret Smyth

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. A. Fallon
(Address) Bonners Ferry Ida

15.
Filed Dec. 28th 1914 E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw h im alive on Dec. 2 — 1914 and that death occurred on the date stated above, at 1 15 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

(Duration) 2a yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. E. Fry M. D.
12/29 1915 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 12/29 1914

20. UNDERTAKER: L. V. Moore — ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10433B

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Died in Country

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David H. Haner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH. May (Month) 15 (Day) 1840 (Year)

7. AGE 74 Yrs. 3 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER D. H. Haner

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Viola M. Olin
(Address) Tiffond Idaho.

15. Filed Aug 28 1914 H.N. Gregg Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1914, to Aug 27 1914, that I last saw h.m. alive on Aug 22 1914, and that death occured on the date stated above, at 11. P. M.

The CAUSE OF DEATH* was as follows:
Heart failure due to acute indigestion.

.....(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) Gall stones

.....(Duration — yrs. — mos. — ds.

(Signed) H. N. Gregg. M. D.

19.. (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston Ida. — DATE OF BURIAL Aug 30 1914

20. UNDERTAKER W.B. Williamson — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 10700
Registered No. .....

1. PLACE OF DEATH.
County of Clearwater
City of Elk River

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Minnesette

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ✓ (Month) ✓ (Day) 1 (Year)

7. AGE: About 30 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): Lumber.

9. BIRTHPLACE (State or Country) ✓

10. NAME OF FATHER: August Minnesette

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Coroner Wilfong.
(Address) Orofino.

15. Filed Oct. 191 4 A L Booke M.D. Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 10 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1914 to Oct. 10 1914 that I last saw h. Mm alive on ✓ 191 . and that death occured on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:
Accidental Homicide.
Shot wounds.
Sudden (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) A L Booke M. D.
Oct 10 1914 (Address) Elk River, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191 .....

20. UNDERTAKER C L Shaver | ADDRESS Colfax Wn

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
(No. ....., ... St.)

File No. 1054
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank E. Wilson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Don't Know — 1 (Month) (Day) (Year)

7. AGE: about 27 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L B McCarlon
(Address) Moscow

15. Filed May 14 1915 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 25 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suicide - body found May 12 1915 and identified
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L B McCarlon Coroner
May 13 1915 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: May 16 1915

20. UNDERTAKER: Geo Stultz — ADDRESS: Moscow

BYMS - YORK CO., PTRS. & BDRS. 19760

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 10803

Name Frank Wilson

Date of Death Oct. 25. 1915. Suicide by Pistol Shot

Cause of Death

Contributary Cause of death

(Sign here) _____ M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
File No. 1099

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone (No. ....., ... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice M Stocking

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): married

6. DATE OF BIRTH: Nov 21 1877 (Month) (Day) (Year)

7. AGE: 36 yrs ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Ira Hill

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: E Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. C. Stocking
(Address) Shoshone

15. Filed 2/14 1914 C. F. Zellers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 13 1914 (Month) (Day) (Year) 191....

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30 191.., to Feb. 13 1914 that I last saw h~~er~~ alive on Feb. 12 1914 and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:
Influenza
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Broncho Pneumonia
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) Chas. F. Zellers M. D.
2/13 1914 (Address) Shoshone, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: Feb. 16 1914

20. UNDERTAKER: C J Barman — ADDRESS: Shoshone

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16

Primary Registration District No. 2016

(No. ....., ... St.)

File No. 1091

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Williams-Peck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Feb 28 (Month) 1914 (Day) (Year)

7. AGE: 42 yrs 4/12 mos. 2 ds. 3

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Wm G Lane

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles M Peck

(Address) Shoshone, Ida

15. Filed 3/1 1914 C. F. Fellen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 28 (Month) 1914 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to Feb 27 1914, that I last saw h[illegible] alive on Feb. 24 1914 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Acute Dilation of Heart. the result of strain and an Acute Pulminary Tuberculosis

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) 2 yrs. — mos. — ds.

(Signed) C. F. Dell M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Gloucester Mass. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: O F Brannon ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16

Primary Registration District No. 2016

File No. 199

County of Lincoln

City of Shoshone (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cecil Barton Zeigler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): single

6. DATE OF BIRTH: Feb 2 1913
died March 14 1914
1 13 months (Month) 12 days (Day) (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Zeigler Ranch Lincoln Co Idaho

10. NAME OF FATHER: W O Zeigler

11. BIRTHPLACE OF FATHER (State or Country): Penna

12. MAIDEN NAME OF MOTHER: annie Savage

13. BIRTHPLACE OF MOTHER (State or Country): Dayton Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. O. Zeigler
(Address) Shoshone

15. Filed 3/15 1914 C. F. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 14 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1914, to Jan 14 1914, that I last saw h[illegible] alive on Jan 14 1914 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Laryngitis & Capillary Bronchitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F Zeller M. D.
3/15 1914 (Address) Shoshone, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Zeigler Ranch | DATE OF BURIAL: March 15 1914

20. UNDERTAKER: P L Brennan | ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Ketchum
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16
Primary Registration District No. 2016
(No. ....., ... St.)

File No. 1052
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorenzo Vernon Bixby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: October (Month) 21 (Day) 1887. (Year)

7. AGE: 26 yrs. 4 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroading
(b) General nature of industry business, or dstablishment in which employed (or employer): Brakeman.

9. BIRTHPLACE (State or Country): Blackfoot, Bingham Co. Ida.

10. NAME OF FATHER: Frank Henry Bixby

11. BIRTHPLACE OF FATHER (State or Country): Boston, Mass.

12. MAIDEN NAME OF MOTHER: Mary Emily Thomas.

13. BIRTHPLACE OF MOTHER (State or Country): Llenelly South Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Emily Jacobs
(Address) Blackfoot Ida.

15. Filed 3/24 1914 C. F. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 21 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture of Skull
due to a fall
(Duration) Instant yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. F. Zeller M. D.
3/24 1914 (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot, Ida. DATE OF BURIAL: 3/23 1914

20. UNDERTAKER: O. J. Brennan ADDRESS: Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

Primary Registration District No. 2016

File No. 1092

County of Lincoln

City of Shoshone (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andy Oleson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	unmarried

6. DATE OF BIRTH unknown

..... 1 .....
(Month) (Day) (Year)

7. AGE about 73 years

..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Shoal Janitor
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Have Know deceased 7 Years
(Informant) And this all information
Can get
(Address) O. J. Brennan

15.
Filed 3/23 1914 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar. 22 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 15 1913, to Mar. 21 1913, that I last saw h[illegible] alive on Mar. 21 1914, and that death occurred on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:
Interstitial Nefritis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory Cardiac Dilatation
(Secondary)
..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Chas. F. Zeller M. D.
3/24 1914 (Address) Shoshone, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Shoshone, Cemetery — DATE OF BURIAL 3/23 1914

20. UNDERTAKER O. J. Brennan — ADDRESS Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1092
Registered No.

1. PLACE OF DEATH. Registration District No. 16
County of Minidoka Primary Registration District No. 2016
City of Hazelton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irene Mildred Asplund

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 17 (Day) 1912 (Year)

7. AGE: 1 yrs. 10 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Asplund

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Minnie Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno Lenn
(Address) Hazelton

15. Filed Mar 26 1914 C. F. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 25 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 PM Mch 25 1914, to Mch 25 4 PM 1914 that I last saw her alive on Mch 25 1914 and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Cerebrospinal Fever
..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Lenn M. D.
Mch 26 1914 (Address) Hazelton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fathers ranch near Hazelton Idaho
DATE OF BURIAL: Mch 27 1914

20. ~~UNDERTAKER~~ Minister: W L Strange
ADDRESS: Hazelton Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16

Primary Registration District No. 2016

(No. ....., ... St.)

File No. 10922

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Ericksons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH June 23 1873
(Month) (Day) (Year)

7. AGE 41 Years ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Eric Ericsson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Eva Ericsson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mathilda Ericsson
(Address) .....

15. Filed Apr. 6 1914 C. R. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH about April 6 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suicide by rifle bullet through skull.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. R. Zeller M. D.
Apr. 10 1914 (Address) C. R. Zeller

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shoshone	April 10 1914

20. UNDERTAKER	ADDRESS
O. J. Bowman	Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16
Primary Registration District No. 2046
(No. ..... , ... St.)

File No. 1095

Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Domingo Ubarnago

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH
unknown (Month) (Day) ~~1874~~ (Year)

7. AGE 47 years ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Sheep Herder
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Spain

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Domingo Sologaga

15.
Filed Shoshone 191 C F Zeller Local Registrar
Apl 11 1914

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 10 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1914, to April 9 1914, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Rocky Mt - Tick fever
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Tuberculosis
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C F Zeller M. D.
4/11 1914 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shoshone	May 11 1914

20. UNDERTAKER	ADDRESS
O J Brennan	Shoshone

SYMS - YORK CO., PTRS. & BDRS. 1970

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16
Primary Registration District No. 2016
(No. ____, ____ St.)

File No. 1093
Registered No. ____
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Lorne Silva

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	White	widow

6. DATE OF BIRTH
December 17th 1883
(Month) (Day) (Year)

7. AGE
30 yrs. 4 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) ....

9. BIRTHPLACE (State or Country) Wyoming

10. NAME OF FATHER Francis M Barker

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Lucy L. Yoran

13. BIRTHPLACE OF MOTHER (State or Country) Syracuse, New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucy L. Silva
(Address) Shoshone, Ida

15.
Filed 4/20 1914 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Apr. 19 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 10 1914, to Apr. 19 1914, that I last saw her alive on Apr. 17 1914 and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Influenza followed by
Acute Tuberculan Pneumonia
(Duration) ... yrs. ... mos. ... ds.
Contributory
(Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. F. Zeller M. D.
4/20 1914 (Address) Shoshone, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone
DATE OF BURIAL: 4/22 1914

20. UNDERTAKER: O. J. Brennan
ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Richfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16
Primary Registration District No. 2016
(No. ....., ... St.)

File No. 1092
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert D Crothers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH 7 of Feb 1878
(Month) (Day) (Year)

7. AGE 36 yrs 2 mo 8 days
.....yrs. .....mos. .....ds.
If LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER Rolla D Crothers

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Josephine Campbell

13. BIRTHPLACE OF MOTHER (State or Country) Long Island N Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence B Crothers
(Address) Shoshone

15. Filed 5/17 1914 C. F. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6th 1914, to May 16 1914, that I last saw h[illegible] alive on May 16 1914 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Spotted (Tick) Fever

(Duration) about 16 days yrs. mos. ds.

Contributory (Secondary) .....
(Duration) .....yrs. .....mos. .....ds.

(Signed) J C Davis M. D.
5/16 1914 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Shoshone — DATE OF BURIAL May 16 1914

20. UNDERTAKER O J Bowman — ADDRESS Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lincoln — Registration District No. 16

City of Shoshone — Primary Registration District No. 2016 — File No. 1902

(No. ..... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Nicolia Washburn

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female | 4. COLOR OR RACE: white | 5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): Wid

6. DATE OF BIRTH: Dec 8 1914
(Month) (Day) (Year)

7. AGE: 1 yrs. month mos. 8 days ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shoshone

10. NAME OF FATHER: John Washburn

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Mary Grisetti

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Washburn
(Address) Shoshone

15. Filed Dec 17 1914 C.A. Zellers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
..... (Month) ..... (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1914, to Dec 16 1914
that I last saw h alive on Dec 16 1914
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: Jan 17 1915

20. UNDERTAKER: J Barman — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

Registration District No. 5

Primary Registration District No. 2016

(No. ..... St.)

File No. 1092

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Lombard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. unknown

(Month) (Day) (Year)

7. AGE: 32 years

.....Yrs.....Mos.....ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Shoeshiner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O J Brennan

(Address) No other informant

15. Filed 12/21 1914 C. F. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 19 1914

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....1914....., to .....1914.....,

that I last saw h.....alive on .....1914.....,

and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Gun Shot wound of neck.

Instantaneous

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Chas. A. Zeller Coron M. D.

12/21 1914 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone Cemetery — DATE OF BURIAL: 12/21 1914

20. UNDERTAKER: O J Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 2016
File No. 1092
Registered No. .....

1. PLACE OF DEATH.
County of Elmore
City of Featherville
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Shannon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH.
unknown (Month) ..... (Day) 1 (Year)

7. AGE about 50 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE
(State or Country) Virginia

10. NAME OF FATHER
unknown

11. BIRTHPLACE OF FATHER
(State or Country) unknown

12. MAIDEN NAME OF MOTHER
unknown

13. BIRTHPLACE OF MOTHER
unknown
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. H. Harris
(Address) Mackay Idaho

15. Filed 12/23 191 4 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 21 (Day) 191 4 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Carcinoma Epithelioma
Patient died on train No. 4
Dec. 21/14
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Zeller M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Caldwell, Ida	191...

20. UNDERTAKER	ADDRESS
O. J. Brennan	Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SRBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

Registration District No. 5

Primary Registration District No. 2016.

(No. ..... St.)

File No. 1054

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kate O'hara

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	white	now married

6. DATE OF BIRTH.

Dec 24 (Month) (Day) 1879 (Year)

7. AGE

35 years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer)... invalid

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John O'hara

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Mullen

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D J Brennan

(Address) Shoshone

15. Filed 12/26 1914 C. H. Zeller Local Registrar

BYRNE - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 24 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1914, to Dec. 24 1914, that I last saw her alive on Dec. 24 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Emphysema of Lungs

(Duration) 3½ yrs. ..... mos. ..... ds.

(Signed) Chas. H. Zeller M. D.

Dec 24 1914 (Address) Shoshone Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: Dec. 26 1914

20. UNDERTAKER: D J Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 110

Registered No. 19

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 7001

County of Ada

Primary Registration District No.

City of Eagle (If not in incorporated limits, give township) (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Almeda Gilbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1914 (Year)

7. AGE: 2 yrs. 2 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Infant None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Payette Idaho

10. NAME OF FATHER: William H Gilbert

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Maggie Coyburn

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Coyburn
(Address) Eagle Ada Co.

15. Filed Dec 23 1914 (Signed) C C Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1914, to Dec 23 1914, that I last saw her alive on Dec 23 1914, and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:
Coma from Convulsion
from Exhaustion Burns
from Accidental Scalding

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary) Exhaustion Burns

(Duration) — yrs. — mos. 2 ds.

(Signed) C C Hall M. D.

Dec 23 1914 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: 12/24 1914

20. UNDERTAKER: Johnson & Sidwell — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6 [redacted]
Registered No. 2477

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 646 N. Grant St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert E. Burk.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October 6 (Month) (Day) 1906 (Year)

7. AGE: 8 Yrs. 2 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer)... Maryland

9. BIRTHPLACE (State or Country) Maryland

10. NAME OF FATHER John Burk

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Fitz John

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Beatrice A. MacRae
(Address) 1148 N. Arthur

15. Filed 12-26-1914 O. J. Beesley Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 25 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26 – 1914, to Dec 25 – 1914, that I last saw him alive on Dec 25 – 1914, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) Yrs. 1 mos. 1 ds.
Contributory (Secondary) Measles
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Beesley M. D.
12-26 1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Dec 28 1914

20. UNDERTAKER: Gayford and Shumacher — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

11063

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 214
File No. 6 [redacted]
Registered No. 276

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Fourth Street St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vincent F. Deig

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan 27 (Month) (Day) 1888 (Year)

7. AGE: 26 Yrs. 10 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Mail
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER John R. Deig

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Rachaine Stanton

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Vincent Deig
(Address) S 12th ave

15. Filed Dec 11, 1914 O B Stevens Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 11 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1914, to Dec 11, 1914, that I last saw him alive on Dec 10, 1914, and that death occured on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Rheumatism
(Duration) yrs. mos. ds.

(Signed) O B Stevens M. D.
12-11-1914 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida. DATE OF BURIAL: Dec 13 1914

20. UNDERTAKER: Craig Lockard & Thurmaker ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BOOKS, 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 1145
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME C. W. Lillard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... 1 .....
(Month) (Day) (Year)

7. AGE
17 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Worked in Saw mill
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER
Sam Lillard

11. BIRTHPLACE OF FATHER
(State or Country) Ironton mo

12. MAIDEN NAME OF MOTHER
" "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Muleady
(Address) St. Maries

15.
Filed ..... 191...
W. L. Muleady
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan 9 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1914, to Jan 9 1914
that I last saw him alive on " " 1914
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. H. Connell M. D.
19... (Address) St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Maries — DATE OF BURIAL: Jan 12 1914

20. UNDERTAKER: W. L. Muleady — ADDRESS: St Maries

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11151

Registered No. .....

1. PLACE OF DEATH.

County of Kootenai

City of De Smet

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catherina Pierre Anasta

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Sept. (Month) 10th (Day) 1903 (Year)

7. AGE: 10 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Reservation

10. NAME OF FATHER Pierre Anasta

11. BIRTHPLACE OF FATHER (State or Country) Reservation

12. MAIDEN NAME OF MOTHER Mary Madelaine Kalispel

13. BIRTHPLACE OF MOTHER (State or Country) Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pierre Anasta

(Address) De Smet

15. Filed July 19 1914 Jakob Post Asst. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1913, to July 18 1914, that I last saw her alive on July 17 1914, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration 1 yrs. 1 mos. — ds.

(Signed) D. R. Gallard M. D.

6/18 1914 (Address) De Smet, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: De Smet, Ida — DATE OF BURIAL: July 20, 1914

20. UNDERTAKER Acting — ADDRESS

John Post De Smet, Ida

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11152

Registered No. .....

1. PLACE OF DEATH.

County of Kootenai

City of De Smet

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby girl Armstrong / nnnnn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. June (Month) 10 (Day) 1914 (Year)

7. AGE .....Yrs. 3 Mos. .....ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) DeSmet (Reservation

10. NAME OF FATHER William Armstrong

11. BIRTHPLACE OF FATHER (State or Country) not Known

12. MAIDEN NAME OF MOTHER not Known

13. BIRTHPLACE OF MOTHER (State or Country) not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Armstrong

(Address) De Smet, Idaho

15. Filed Oct 10 1914

John Test, Asst.
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191....., that I last saw h.....alive on .....191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows: not Known

No attendance

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) John Test, Asst. R...

.....19..... (Address) De Smet, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL Tekoa, Wash.

DATE OF BURIAL Oct. 11 1914

20. UNDERTAKER C. L. Schuleveid

ADDRESS Tekoa, Wash

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of DeSmet

Registration District No. 31

Primary Registration District No.

(No. ..... St.)

File No. 11153

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lydia Pelotkan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 18 (Day) 1914 (Year)

7. AGE ..... Yrs. ..... Mos. 1 dy.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Reservation

10. NAME OF FATHER Paul Pelotkan

11. BIRTHPLACE OF FATHER (State or Country) Reservation

12. MAIDEN NAME OF MOTHER Lucy Nicholson

13. BIRTHPLACE OF MOTHER (State or Country) Colville Reserve

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Pelotkan

(Address) DeSmet, Idaho

15. Filed July 20 1914 John Post Asst. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

no physician. Nat
Tuberc

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Leonard M. D.

6/18 1914 (Address) Drumm Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ DeSmet, Ida. DATE OF BURIAL July 20 1914

20. UNDERTAKER Rotting — ADDRESS John Post DeSmet Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

1121

V.S. No. 1

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County of Kootenai

~~City or~~ Town of Worley

Registration Dist. No. .....

WASHINGTON STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. [redacted]

File No. 3 [redacted]

Registered No. 32

(No. ....., ... St.; ..... Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

Full Name Martin Walser

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: m

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: Jan. (Month) 31 (Day) 1847 (Year)

7 AGE: 67 yrs. 10 mos 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Ill.

PARENTS

10 NAME OF FATHER: H. T. Walser

11 BIRTHPLACE OF FATHER (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Zula Walser
(Address) Worley Ida

15 Filed 1-2-, 1915. W. R. Watson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) 29 (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from [redacted], 191..., to ....., 191...., that I last saw h..... alive on ....., 191...., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH * was as follows:
Was probably due to
Myocarditis. Last
examined him about 1 yr ago
He retired moderately well
was found dead next
morning
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (SECONDARY) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Cushing, M. D.
1-2- 1915 (Address) Fairfield Wn.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Only Suspicious about death

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Fairfield Cemetery — DATE OF BURIAL: 12-31- 1914

20 UNDERTAKER: A. L. Stinson — ADDRESS: Fairfield Wn

Died at worley, Ida.

11257

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Ada. Primary Registration District No. 2006

File No. [redacted]

City of 2½ mi S.E. Nampa (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME A. C. Banks.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH: Aug. 6th 1840
(Month) (Day) (Year)

7. AGE: 74 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Isreal Banks.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Mary Clothier

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm. A. McKelloy M.D.
(Address): Nampa Ida.

15. Filed July 24 191 Dr S D Calonge
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 23rd 1914.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1914, to July 23, 1914, that I last saw him alive on July 23, 1914, and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. 1½ hrs. ds.

Contributory (Secondary) Arteriosclerosis

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) Wm. A. McKelloy M. D.

7/24/1914 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Iowa.	..... 191...

20. UNDERTAKER	ADDRESS
L. B. Kellogg	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

1125

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1006
(No. , St.)

File No. [redacted]
Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Mangum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: March (Month) 16 (Day) 1830 (Year)

7. AGE: 84 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): U.S.

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Irvin Bissett
(Address) Nampa Ida

15.
Filed July 16 1914 W. R. Calonge Local Registrar
Thos. Hatfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 to 1914, to July 15 1914 that I last saw him alive on July 15 1914, and that death occurred on the date stated above, at 10:30 a. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

(Duration) yrs. mos. 2 ds.

Contributory (Secondary): Hot Weather

(Duration) yrs. mos. ds.

(Signed) J. H. Murray M. D.
July 16 1914 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death [redacted] mos. ds. In the State yrs. mos. ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: 7/16 1914

20. UNDERTAKER: F. H. Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1129

Registered No. .....

1. PLACE OF DEATH.

County of Kootenai

City of Chatcolat

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. Timothy L. Harrington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 25 (Day) 1886 (Year)

7. AGE. 28 yrs. 8 mos. 17 ds. 37 27

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: RR Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Tim Harrington

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Beuchat

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose G. Harrington

Address: Edgerton, Wisconsin

15. Filed June 22 1915 H. L. Brakeley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 11. (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

A box car fell over him an crushed him.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Brakeley Registrar M. D.

June 22 1915 (Address) H. L. Brakeley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Edgenton, Wisconsin

DATE OF BURIAL: Sept ~~14~~ 15 1915

20. UNDERTAKER: J.D.Buchanan

ADDRESS: Yoakum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRON YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

11295

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [redacted]

Registered No. 209

1. PLACE OF DEATH.

County of Ada

City of Near Locust Grove

(No. near Locust Grove St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.....

Primary Registration District No.....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lolla Beva Batchelder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 13th 1 (Month) (Day) (Year)

7. AGE: 21 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J. D. Miller

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Effie J. Hoagland

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. C. Batchelder

(Address) Meridian Idaho

15. Filed 9 - 1 1914 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31st (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/30 1914, to 8/31 1914, that I last saw her alive on 8/31 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Uraemia

Nephritis Acute

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Eclampsia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Dutton M. D.

19..... (Address) Meridian

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/2 1914

20. UNDERTAKER: Schreiber & Sidebotham — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 11295

Name Lolla Beva Bathhelder

Date of Death Aug. 31, 1915

Cause of Death Puerperal - ?e - Patient was six months
Pregnant - had (Puerpual Eclampsia) (Convulsions) and gave
Contributary Cause of death History of having kidney trouble -
Patient had convulsions several hours before I was called -
depending on faith cure -

(Sign here) C. L. Sutton M.D.

FORM V. S. No. 5-25 M. 1-16-13

11296

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
(No. .... St.)

File No. [redacted]
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Isabel Zabala

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. Jan (Month) 1 (Day) 1872 (Year)

7. AGE: 42 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. F. Chamberlain

11. BIRTHPLACE OF FATHER (State or Country) Ohio -

12. MAIDEN NAME OF MOTHER Mary Danielson

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ignacio Zabala
(Address) Nampa Ida

15. Filed July 13 1914. Dr S D Calonder Local Registrar
Registrar Jaquith Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1914, to July 13 1914, that I last saw h er alive on July 13 1914, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Peritonitis (general) following hysterectomy (fibroma)
(Duration) 1 Yrs. mos. 5 ds.
Contributory (Secondary) Valvular heart lesion
(Duration 10 yrs. mos. ds.
(Signed) H. P. Ross M. D.
July 13 1914 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rollerlawn Nampa — DATE OF BURIAL: July 14 1914

20. UNDERTAKER: F. P. Robinson — ADDRESS: Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. [redacted]

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Boise

City of Sweet

(No. ....., ... St.)

Registration District No. 13

Primary Registration District No. 2024

File No. 1[illegible]

Registered No. 1[illegible]

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Gooden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): MARRIED

6. DATE OF BIRTH. March (Month) 30th (Day) 1878 (Year)

7. AGE: 36 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Marion Co. Missouri

10. NAME OF FATHER: H. C. Gooden

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. G. Boyd

(Address) Sweet

15. Filed ..... 191.... A. G. Boyd Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15th 1914, to April 16 1914, that I last saw him alive on April 16th 1914, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

~~Primary~~ Secondary Anemia

(Duration) ..... Yrs. ..... mos. 1 Wk ds.

Contributory (Secondary) Epistaxis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. G. Boyd M. D.

19..... (Address) Sweet, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ola, Idaho

DATE OF BURIAL: Apr. 1[illegible] 1914

20. UNDERTAKER: T. D. Buckmann Ucko

ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1114

Registered No. 251

1. PLACE OF DEATH.
County of Bannock
City of Soda Springs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 216
(No. ~~Dominick Iparano~~ St.)

2. FULL NAME Dominick Iparano

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH
(Month) (Day) (Year): 1

7. AGE: about 55 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O P Steely
(Address) Pocatello Idaho

15.
Filed Aug 24 1915 O P Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
About July 15 or 16th 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191...
that I last saw h— alive on ——— 191...,
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Murdered - throat cut.

(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) ✓
(Duration) ... yrs. ... mos. ... ds.
(Signed) O P Steely M. D.
Aug 24 1915 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soda Springs — DATE OF BURIAL: July 20 1914

20. UNDERTAKER: Walker & T. — ADDRESS: Pocatello Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

County of Ada

City of

Registration District No. 1007

Primary Registration District No. 10

(No. 3 miles so. of Meridian Idaho St.)

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11850

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert J. Peterson.

The information on this certificate is an exact COPY of the official certificate filed at place of death.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. Single, Married, Widowed or Divorced. (Write Word): Single

6. DATE OF BIRTH. Aug (Month) 16 (Day) 1839 (Year)

7. AGE: 75 Yrs 3 Mos 11 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Jacob Peterson

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Jane Willis

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L. J. Peterson
(Address): R. Meridian

15. Filed Nov 29 1914 [illegible]
Local Registrar.

Place Where Remains are to be Sent.

Date of Shipment ____ 191...

SHIPPING UNDERTAKER

ADDRESS ____ Firm Name ____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Nov (Month) 28 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1914., to Nov 28 1914., that I last saw him alive on Nov 27 1914., and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH was as follows:

Paralysis

(Duration) ____ Years ____ mos. 11 ds.

Contributory (Secondary) ____

(Duration) ____ Years ____ mos. ____ ds.

(Signed) Chas. L. Payne M. D.

191... (Address) ____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place of death ____ yrs ____ mos ____ days

In the State ____ yrs ____ mos ____ days

Where was disease contracted if not at place of death ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL [redacted] Date of Burial Nov 29 1914

20. UNDERTAKER D. L. Ayres

Address

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11857

Registered No. .....

Registration District No. 86

Primary Registration District No. 1010

1. PLACE OF DEATH.

County of Washington

City of Weiser (No. West Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Jesse W O'Leary

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. 9 (Month) 26 (Day) 1877 (Year)

7. AGE 37 Yrs. 9 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Battle Creek Mich.

10. NAME OF FATHER C. Richard

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) Battle Creek Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. O'Leary
(Address) .....

15. Filed July 20 1914 W. R. Hamilton Local Registrar
L.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1914, to July 19 1914, that I last saw h[illegible] alive on July 17 1914, and that death occured on the date stated above, at ? M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Lungs
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Dom Kreus
(Duration yrs. mos. ds.

(Signed) S. B. Dudley M. D.
19 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Weiser Idaho | DATE OF BURIAL 191...

20. UNDERTAKER R. W. Bowen | ADDRESS Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24858

CERTIFICATE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5

Primary Registration District No. 2016

(No. ....., ... St.)

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11864

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Willis Campbell

This certificate is an exact COPY of the official certificate filed at place of death.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed or Divorced. (Write the Word): married

6. DATE OF BIRTH. Sept. 22 (Month) (Day) 1891 (Year)

7. AGE: ..... Yrs 22 Mos 2 ds. —

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ann B. Campbell
(Address) .....

[redacted] ....1915 J. L. Fuller
Local Registrar.

[redacted] are to be Sent. | Date of Shipment .....191...

Shoshone Cemetery

SHIPPING UNDERTAKER

ADDRESS ..... Firm Name [redacted]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH.
July (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1914., to July 8 1914.,
[redacted] I last saw h[redacted] alive on July 8 1914.,
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH was as follows:
Mitral Regurgitation
Cardiac Dilatation
.....
.....(Duration) .....Years .....mos.. ..ds.

Contributory (Secondary) .....

..... (Duration) .....Years.....mos.....ds.

(Signed) Thos. F. Gelbon M. D.
July 8 1914. (Address) Shoshone, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death....yrs....mos....days
In the State ....yrs...mos...days

Where was disease contracted if not at place of death .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Shoshone Ida. | Date of Burial July 9 1914.

20. UNDERTAKER P. F. Brennan | Address Shoshone

[redacted] CATE OF DEATH

Form V. S. No. 5 20M.1-16-12

Registration District No. 97

Primary Registration District No. 2174

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 12334

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lapwai

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia A Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH: June (Month) 26 (Day) 1839 (Year)

7. AGE: 75 yrs. 11 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): -Mo-

10. NAME OF FATHER: Theopolus Shaw.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Elizabeth Leachman

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred A. Miller
(Address) Lapwai. Idaho.

15.

Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 7 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 - 1914, to June 7 1914, that I last saw h[illegible] alive on June 6 - 1914, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary): Cardiac Failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

June 8 1914 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac, Idaho. DATE OF BURIAL: June 10 1914

20. UNDERTAKER: W. A. Hoddard ADDRESS: Gifford. Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

12709

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2211
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Eliza Crooks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Jan (Month) 5 (Day) 1866 (Year)

7. AGE: 38 yrs. 7 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Arkansaw

10. NAME OF FATHER: Woodwoth Wyat

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Jane Ingalls

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Crooks
(Address) Troy Ida.

15. Filed Aug 15 1914 C. V. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 1 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1914, to Aug 1 1914
that I last saw her alive on July 30 1914
and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) 2 yrs. — mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. M. Crooks M. D.
Aug 1 1914 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane
DATE OF BURIAL: Aug 4 1914

20. UNDERTAKER: Stelly
ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14159

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH.

[redacted] Bear Lake
Geo Town

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydia Melissa Payne

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Sept. (Month) 10 (Day) 1912 (Year)

7. AGE: 2 yrs. 1 mos. 29 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Lot Payne

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Hattie Hays

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Reported by Alma Hayson
(Address) Via Form — Ind.

15. Filed Nov 8 1914 Marion C. Clay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 8 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1914, to Nov 8 1914, that I last saw her alive on Nov 7 1914, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Scarlet Fever

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo F Cudlipp M. D.

Nov 8 1914 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Georgetown Idaho	Nov 8 1914

20. UNDERTAKER	ADDRESS
Gilbert Walker	Georgetown Ida.

SYMS - YORK CO., PTRS. & BDRS. 10760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14161

Registered No.

1. PLACE OF DEATH.

County of Bear Lake

City of Georgetown

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Noud Rasmussen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Nov. (Month) 25 (Day) 1914 (Year)

7. AGE: ..... yrs. ..... mos. four ds. weeks

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgetown, Idaho

10. NAME OF FATHER: James Rasmussen

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary Barkdull

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Recieved from Alma Hayes
(Address) on old form — J. M. S.

15. Filed Dec 31 1914 Marion L. Clark Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 31 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1914, to Dec 31 1914 that I last saw h.. alive on Dec 30 1914 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. F. Chidley M. D.

Jan 1 1915 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Georgetown Ida. DATE OF BURIAL: ..... 191..

20. UNDERTAKER: Gilbert Welker ADDRESS: Georgetown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14890

Registered No. .....

Registration District No. 3

Primary Registration District No. 2016

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph C. May

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 25 (Day) 1876 (Year)

7. AGE: 28 Yrs. ..... Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER Josia May

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Louisa Ann May

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Barbara May
(Address) .....

15. Filed July 22 1914 C. T. Zeller Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1912, to July 18 1914, that I last saw h[illegible] alive on July 16 1914, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Gastro Enteritis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. T. Zeller M. D.

July 1914 (Address) Shoshone, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone Cemetery — DATE OF BURIAL: July 21 1914

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15983

Registered No. .....

1. PLACE OF DEATH.

County of BOISE

City of Horse-Shoe Bend

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Reid

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 8 (Day) 1860 (Year)

7. AGE: 54 Yrs. 7 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Cattle-man

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Newry, Ireland

10. NAME OF FATHER James Reid

11. BIRTHPLACE OF FATHER

(State or Country) Ireland Newry

12. MAIDEN NAME OF MOTHER Mary Hannah

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lizzie Reid

(Address) Horse Shoe Bend

15.

Filed ..... 191.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October (Month) 5th (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach.

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed).....M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Horseshoe Bend Cemetery	Oct. 7-1914
20. UNDERTAKER	ADDRESS

SYMS - YORK CO., PTRS. & BOOK. 24658

J. M. S.

Form V. S. No. 5—12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No. 2124
File No. 18609
Registered No. 5

1. PLACE OF DEATH.
County of Lewis
City of Nezperce (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME May Bell Swartz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: May (Month) 9 (Day) 1867 (Year)
7. AGE: 47 yrs. 1 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Pontiac, Ill
10. NAME OF FATHER: Joseph Connley
11. BIRTHPLACE OF FATHER (State or Country): U. S.
12. MAIDEN NAME OF MOTHER: Connley
13. BIRTHPLACE OF MOTHER (State or Country): U. S.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Swartz
(Address) Nezperce Ida
15. Filed 8/1 1917 J. W. Robertson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 26 (Day) 1917 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1917, to Jun 24 1917
that I last saw her alive on Jun 24 1917
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Pernicious Anaemia
..... (Duration) + yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. A. Jeffreys M. D.
Jun 29 1917 (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Nezperce
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: A. C. Miller
ADDRESS: Nezperce

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17143

Form V. S. No. 1. Rev. 1915

CERTIFICATE OF DEATH

State of Idaho

47

1. PLACE OF DEATH. Registration District No. [illegible]

County of [illegible] Primary Registration District No. 2124

File No. 1864

City of [illegible] (No. [illegible] St.)

Registered No. [illegible]

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nathaniel G. Looney

If death occurred in hospital, institution or camp give name instead of street address.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January (Month) 8 (Day) 1852 (Year)

7. AGE: 62 yrs. 5 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): U. S.

10. NAME OF FATHER: A. Looney

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bessie C. Browning
(Address) Nezperce

15. Filed 8/15/ 191[illegible] J. O. Robertson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 9 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/4 191[illegible], to 6/9 191[illegible] that I last saw h[illegible] alive on June 9 191[illegible] and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Liver.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Kelly M. D.

6/11 191[illegible] (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce DATE OF BURIAL: [illegible] 191[illegible]

20. UNDERTAKER: H. E. Miller ADDRESS: Nezperce

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 21792
Registered No. 52

1. PLACE OF DEATH.
County of Bear Lake
City of Bet Lake
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orsons Waldrann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: 8 (Month) 3 (Day) 1858 (Year)

7. AGE: 55 yrs. ..... mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Lorenzo Waldrann

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Maria Butters

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Agnes [illegible]
(Address): Liberty Utah

15.
Filed 8-12 1914 G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 9 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Nephritis
.....
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
(Duration) 11 yrs. ..... mos. ..... ds.
(Signed) C M Hansen M. D.
19 (Address) Salt Lake City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 8-12 1914

20. UNDERTAKER: J. R. Young
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho.
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25145

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Washington

City of Midvale

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Polly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1883 (Year)

7. AGE: 31 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer & Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: James M. Polly

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Elizabeth Hadden

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J A Hadden

(Address) .....

15. Filed Mar 10 1919 W B Marshall M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 29 (Month) ..... (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1914, to Apr 26 1914, that I last saw h alive on Apr 26 1914, and that death occured on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

..... (Duration) 2y. Yrs. 1 mos. ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W B Marshall M. D.

19..... (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....

DATE OF BURIAL: ..... 191.....

20. UNDERTAKER: Roy Deloshmutt

ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FILE # 30046

YEAR 1914

IDAHO DEATH CERTIFICATE

☑ **VOID**

☑ **VOID**

☑ **VOID DUP OF 1914-08338**

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30046
Registered No. .....

Registration District No. 59-2
Primary Registration District No. 2139

1. PLACE OF DEATH
County of Butte
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 20 miles west of Arco St.)

2. FULL NAME Alfred A. Brim

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH. June (Month) 24 (Day) 1868 (Year)

7. AGE 46 Yrs. 10 Mos. 18 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Alexander Brim

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Anna M. Bishop

13. BIRTHPLACE OF MOTHER (State or Country) Greece N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Brim
(Address) 834 So. 10 East St. Salt Lake City Utah

15. Filed 4/13 1914 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 14 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h...alive on ..... 191...
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Suicide by Shot

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary)

6/13 (Duration) ..... Yrs..... mos. ..... ds.

(Signed) ..... M. D.

.....19 14 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs....mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death? .....

Former or usual residence Salt Lake City Utah

19. PLACE OF BURIAL OR REMOVAL Salt Lake City Utah — DATE OF BURIAL .....191...

20. UNDERTAKER H. L. McClain — ADDRESS Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ....., (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33240
Registered No.

RECEIVED
APR [illegible] 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. Elmore Co
County of Owyhee
City of King Hill Proj. (or Village, or Township, or Precinct) Registration District No. Elmore Co St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christian Bohren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	single

6. DATE OF BIRTH: December (Month) 2 (Day) 1862 (Year)

7. AGE: 51 Yrs. 3 Mos. 19 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grindelwald Switzerland

10. NAME OF FATHER: Christian Bohren

11. BIRTHPLACE OF FATHER (State or Country): Grindelwald Switzerland

12. MAIDEN NAME OF MOTHER: Maria Bohren

13. BIRTHPLACE OF MOTHER (State or Country): Grindelwald Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Bohren
(Address) King Hill, Idaho

15. Filed March 24 1914 J. W. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 21 (Month) (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1914 to March 21 1914 that I last saw him alive on March 21 1914, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Rocky mountain Spotted fever or Tick fever
(Duration) 1 Yrs. mos. 10 ds.
Contributory (Secondary) Tick Bite
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. W. Davis M. D.
March 25 1914 (Address) Glenns Ferry Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 1 mos. 20 days. In the State 5 yrs. 1 mos. 20 days
Where was disease contracted if not at place of death? Elmore County, Ida
Former or usual residence Minden, Iowa

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Glenns Ferry Idaho	Mch 24 1914
20. UNDERTAKER	**ADDRESS**
C R Altmannsperger	King Hill, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 3 1955
Division of Vital Statistics

Certificate of Death

STATE OF IDAHO

No. 156494

Local Reg. No.

Reg. Dist. No.

BIRTH NO. OCT 3 1955

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arrowrock Dam
c. LENGTH OF STAY (in this place) 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arrowrock Dam
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NYE	FORESTER	MORTON	Sept. 4, 1914

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	July 22, 1869	45-1-12				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Granby, Massachusetts
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Albert Morton — BIRTHPLACE Liberty, N. Y.
14. MOTHER'S MAIDEN NAME Mary Anne Kellogg — BIRTHPLACE Westminster, Vermont

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Paul L. Morton — ADDRESS 1530 Euclid Berkeley 4, California

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) s/ Dr. Kirby
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/7/1914	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Clyde E. Summers — ADDRESS Boise, Idaho
SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DPH-48021